**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?** | **MEDICAL**<br>**$5,000 / Ind**<br>**$9,000 / Family** | **PRESCRIPTION**<br>**$1,000 / Ind**<br>**$2,000 / Family** | 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. The medical and prescription deductibles accumulate separately. |
| **Are there services covered before you meet your Deductible?** | **Yes. Preventive Services are covered before you meet your Deductible** | | This Plan covers Preventive Services even if you haven't yet met the Deductible amount. See a list of covered Preventive Services at located at the ACA website by visiting https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other Deductibles for specific services?** | **No** | | Not Applicable. |
| **What is the Out-of-Pocket Limit for this Plan?** | **MEDICAL**<br>**$7,900 / Ind**<br>**$16,000 / Family** | **PRESCRIPTION**<br>**$1,200 / Ind**<br>**$2,100 / Family** | The Out-of-pocket Limit is the most you could pay in a plan year for covered services. If you have family members on this Plan, they have to meet their own Out-of-Pocket Limits until the overall family Out-of-Pocket Limit has been met. The medical and prescription out-of-pocket limits accumulate separately. |
| **What is not included in the Out-of-Pocket Limit?** | **Premiums, Balance Billing, Penalties, Services not Covered by this Plan, Fees above RBP and/or UCR** | | Even though you pay these expenses, they don't count towards the Out-of-Pocket Limit. |
| **Will you pay less if you use a Network Provider?** | **Not Applicable** | | This Plan does not use a Provider Network. You may receive covered services from any provider. |
| **Are there prescription services?** | **Yes** | | Prescription services are available through Optum Rx.<br>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 any Specialist you choose without a Referral. |

[* 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 visit a health care Provider's office or clinic** | Primary Care Visit to Treat an Injury or Illness | $50 Copay per Office Visit** *Plan Pays Max $150/Visit | Deductible Waived. Unlimited Visits. After copay, plan pays 150% of Medicare reimbursement rates, up to plan limits*. In the absence of a Medicare rate, plan pays UCR rates. Any remaining balance after the Plan has paid is the responsibility of the Member and will not be applied to the deductible. **Additional Charges for Labs, X-Rays, Tests, and Imaging are Subject to Those Applicable Copays and Limitations. |
| | Specialist Visit | $100 Copay per Office Visit** *Plan Pays Max $300/Visit | |
| | 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 pays UCR rates. You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. If you receive a bill from a provider for Preventive Services, call Planstin Member Services at 888-920-7526. |
| **If you have a test** | Diagnostic Test (X-Ray) *Plan Pays Max $250/X-Ray | Tier I: $50 Copay per X-Ray Tier II: $200 Copay per X-Ray | Diagnostic Test (X-Ray) – Limit of 5 X-Rays per Member per Plan Year<br>Lab/Bloodwork – Limit of 15 Labs per Member per Plan Year<br>Imaging – Limit of 2 Tests per Member per Plan Year<br>Tier I: Performed in Physician's Office or Free-standing Facility<br>Tier II: Performed in a Hospital or Hospital Affiliated Outpatient Facility<br>Deductible Waived. After copay, plan pays 150% of Medicare reimbursement rates, up to plan limits*. In the absence of a Medicare rate, plan pays UCR rates. Any remaining balance after the Plan has paid is the responsibility of the Member and will not be applied to the deductible. |
| | Lab/Bloodwork *Plan Pays Max $100 per Lab | Tier I: $20 Copay per Lab Tier II: $50 Copay per Lab | |
| | Imaging (CT/PET Scans, Ultrasounds, MRIs) *Plan Pays Max $1,000/Test | Tier I: $350 Copay per Test Tier II: $500 Copay per Test | |
| **If you need drugs to treat your illness or condition More information about Prescription Drug discounts is available at rx.planstin.com** | Tier 1 - Generic | Retail: $10 Copay Mail Order: $20 Copay | Deductible Waived for Tiers 1-3 / ACA Preventive drugs are covered 100%. 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 copay. Some drugs may require a prior authorization or step therapy. Specialty Drugs subject to medical necessity requirements. ***Plan pays a maximum of $500 per Specialty RX. Cost of RX over the $500 max will be the member's responsibility and will not be applied to member's deductible or OOP and will be the responsibility of the member.** |
| | Tier 2 - Preferred Brand | Retail: $50 Copay Mail Order: $100 Copay | |
| | Tier 3 - Non-Preferred Brand | Retail: $100 Copay Mail Order: $100 Copay | |
| | Tier 4 – Specialty | 20% Coinsurance **AFTER** Deductible is Met* | |
| **If you have outpatient surgery** | Facility Fee / Ambulatory Surgical Center | 20% Coinsurance **AFTER** Deductible is Met | After Deductible, plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a Medicare rate, plan pays UCR rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations & conditions. |
| | Physician/Surgeon Fees | 20% Coinsurance **AFTER** Deductible is Met | |
| **If you need immediate medical attention** | Emergency Room Care | $500 Copay per Visit | **EMERGENCIES ONLY**. Deductible Waived. After copay, plan pays 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan pays UCR. |
| | Emergency Medical Transportation | $500 Copay per Visit | |
| | Urgent Care | $100 Copay per Visit *Plan Pays Max $300/Visit | Applies to **URGENT CARE FACILITIES ONLY**. Deductible Waived. After copay, plan pays 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan pays UCR. Any remaining balance after the Plan has paid is the responsibility of the Member and will not be applied to the deductible. |

[* 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) | 20% Coinsurance **AFTER** Deductible is Met | After Deductible, plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a Medicare rate, plan pays UCR rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions. |
| | Physician/Surgeon Fees | 20% Coinsurance **AFTER** Deductible is Met | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient Services | 20% Coinsurance **AFTER** Deductible is Met | After Deductible, plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a Medicare rate, plan pays UCR rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions. |
| | Inpatient Services | 20% Coinsurance **AFTER** Deductible is Met | |
| **If you are pregnant** | Office Visits | $50 Copay per Visit Deductible Waived | After copay, plan pays 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan pays UCR rates. |
| | Childbirth / Delivery Professional Services | 20% Coinsurance **AFTER** Deductible is Met | After Deductible, plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a Medicare rate, plan pays UCR rates. |
| | Childbirth / Delivery Facility Services | 20% Coinsurance **AFTER** Deductible is Met | |
| **If you need help recovering or have other special health needs** | Home Health Care | 20% Coinsurance **AFTER** Deductible is Met | Home Health Care: Limit of 60 Visits per Member per Plan Year<br>Rehabilitation Services & Habilitation Services: Limit of 120 Visits (Combined) per Member per Plan Year and Includes Physical Therapy, Occupational Therapy & Speech Therapy<br>Skilled Nursing Care: Limit of 120 Days per Member per Plan Year<br>Durable Medical Equipment: Limited to $1,000 per Item/Service per Plan Year<br><br>After Deductible, plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a Medicare rate, plan pays UCR rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions. |
| | Rehabilitation Services | 20% Coinsurance **AFTER** Deductible is Met | |
| | Habilitation Services | 20% Coinsurance **AFTER** Deductible is Met | |
| | Skilled Nursing Care | 20% Coinsurance **AFTER** Deductible is Met | |
| | Durable Medical Equipment | 20% Coinsurance **AFTER** Deductible is Met | |
| | Hospice Services | 20% Coinsurance **AFTER** Deductible is Met | |
| | Chiropractor Visits<br>*Limit 12 Visits per Member per Plan Year | $100 Copay per Visit Deductible Waived | After copay, plan pays 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan pays UCR rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions. |
| **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 UCR 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 UCR rates. |

[* For more information about limitations and exceptions, see the plan or policy document at 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 plan year.
- Cosmetic Procedures – Please refer to Summary Plan Description for 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. 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 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.

**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, kwiijigo 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 ofcosts 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** **$5,000**
- **Specialist Visits [Copayment]** **$500**
- **Imaging – Tier II [Copayment]** **$1,000**
- **Lab/Bloodwork - Tier II [Copayment]** **$500**
- **Hospital (Facility) [Coinsurance]** **20%**

**This EXAMPLE event includes services like:**
Specialist Office Visits *(Prenatal Care)*
Diagnostic Tests (*Ultrasound)*
Diagnostic Tests (*Bloodwork Labs)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services *(Including Anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayments | $2,000 |
| Coinsurance | $1,540 |
| *What is NOT Covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$8,640** |

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

- **The Plan's Overall Deductible** **$5,000**
- **Specialist Visits [Copayment]** **$600**
- **Lab/Bloodwork – Tier I [Copayment]** **$125**
- **Durable Medical Equipment [Coinsurance]** **20%**

**This EXAMPLE event includes services like:**
Specialist Visits (*Including Disease Education)*
Diagnostic Tests *(Bloodwork Labs)*
Durable Medical Equipment *(Glucose Meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayments | $725 |
| Coinsurance | $120 |
| *What is NOT Covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$5,845** |

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

- **The Plan's Overall Deductible** **$5,000**
- **Specialist Visit [Copayment]** **$100**
- **ER Facility Services [Copayment]** **$500**
- **Durable Medical Equipment [Coinsurance]** **20%**
- **Rehabilitation/Physical Therapy [Coinsurance]** **20%**

**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*)*

| **Total Example Cost** | **$5,000** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What is NOT Covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$5,600** |

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