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, call a Benefit Advocate at (888) 920-7526. 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 www.healthcare.gov/sbc-glossary.com or call 888-920-7526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,500 / Individual or $7,000 / 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.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,100 / Individual or $14,500 / Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other 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.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance billing charges, services not covered by this plan, fees above RBP rates and/or UCR rates.	Even though you pay these expenses, they don't count toward 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 can receive covered services from any provider.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.
Copayment for office visits apply to visits only. In-office procedures may not be covered.
All covered services are paid at 150% of Medicare reimbursement rates (RBP). In the absence of a Medicare rate the plan will pay UCR.

Common Medical Event	Services You May Need	What You Will Pay Out-of-Network Provider (this plan does not use a network)	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/visit	Deductible waived. Plan will pay up to $150 max/visit. Additional charges are member responsibility, will not be applied to deductible or out-of-pocket limits.
	Specialist visit	$100 copay/visit	Deductible waived. Plan will pay up to $300 max/visit. Additional charges are member responsibility, will not be applied to deductible or out-of-pocket limits.
	Preventive care/screening/ immunization	No Charge	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 receive a bill for preventive services, call a Benefit Advocate at (888) 920-7526.**
If you have a test	Diagnostic test (x-ray, blood work)	Tier I: $50 copay/x-ray and $20 copay/lab Tier II: $200 copay/x-ray and $50 copay/lab	Deductible waived. Tier I: Performed in a physician's office or free-standing facility. Tier II: Performed in a hospital or hospital-affiliated outpatient-facility. Diagnostic services are subject to annual limits. The plan pays up to $250/x-ray and $100/lab. Additional charges are member responsibility and will not be applied to deductible or out-of-pocket limits.
	Imaging (CT/PET scans, MRIs)	Tier I: $350 copay/test Tier II: $500 copay/test	Deductible waived. Tier I: Performed in a physician's office or free-standing facility. Tier II: Performed in a hospital or hospital-affiliated outpatient-facility. Imaging services are subject to annual limits and the plan pays up to $1,000/test.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at PlanstinRx.com	Generic drugs	$10 copay (retail) and $20 copay (mail order)	RX deductibles are $1,000 (individual) and $2,000 (family). RX out-of-pocket limits are $1,200 (individual) and $2,100 (family). ACA Preventive drugs are covered 100%. Plan will pay up to **$500 monthly max per specialty prescription.** Additional costs are the member's responsibility and will not be applied to the deductible or to the out-of-pocket limits.
	Preferred brand drugs	$50 copay (retail) and $100 copay (mail order)	
	Non-preferred brand drugs	$100 copay (retail) and $100 copay (mail order)	
	Specialty drugs	30% Coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	This plan does not cover some types of facility charges. See the Summary Plan Description for more information regarding exclusions.
	Physician/surgeon fees	30% Coinsurance	See the Summary Plan Description for details about services that may not be covered as part of outpatient surgery.

* For more information about limitations and exceptions, see the plan or policy document at https://helpdesk.planstin.com/benefit-information

Common Medical Event	Services You May Need	What You Will Pay Out-of-Network Provider (this plan does not use a network)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$500 copay/visit	**Only covered in an emergency medical event.** Deductible waived. See the Summary Plan Description for more details.
	Emergency medical transportation	$500 copay/visit	**Only covered in an emergency medical event.** Deductible waived. See the Summary Plan Description for more details.
	Urgent care	$100 copay/visit	Coverage for Urgent care facilities only. Deductible waived. Plan will pay up to $300 max/visit. Additional charges are member responsibility and will not be applied to deductible or out-of-pocket limits.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	Inpatient services are covered when medically necessary.
	Physician/surgeon fees	30% Coinsurance	Inpatient care is covered when medically necessary.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% Coinsurance	Services must be medically necessary.
	Inpatient services	30% Coinsurance	See the Summary Plan Description for more information.
If you are pregnant	Office visits	$50 copay/visit	Deductible waived. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or deductible may apply.
	Childbirth/delivery professional services	30% Coinsurance	Charges for professional services at in-home births are not covered.
	Childbirth/delivery facility services	30% Coinsurance	Charges for care received in birthing centers are not covered. See the Summary Plan Description for more details.
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	60 visit limit per plan year.
	Rehabilitation services	30% Coinsurance	120 visit limit (combined with habilitation services) per plan year.
	Habilitation services	30% Coinsurance	120 visit limit (combined with rehabilitation services) per plan year.
	Skilled nursing care	30% Coinsurance	120-day limit per plan year.
	Durable medical equipment	30% Coinsurance	$1,000 limit per Item/Service per plan year.
	Hospice services	30% Coinsurance	Services are covered when prerequisites are satisfied. See the Summary Plan Description for more details.
If your child needs dental or eye care	Children's eye exam	No Charge	No Coverage for vision care, except as otherwise covered in Section VI of the Summary Plan Description.
	Children's glasses	Not Covered	Contacts, lenses, and frames are excluded.
	Children's dental check-up	No Charge	No Coverage for dental care, except as otherwise covered in Section VI of the Summary Plan Description.

* For more information about limitations and exceptions, see the plan or policy document at https://helpdesk.planstin.com/benefit-information

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
- Bariatric Surgery
- Dental Care (Adult)
- Experimental/Investigational Services
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Services that are not Medically Necessary
- Sexual Dysfunction
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care (12 visit annual limit)
- Cosmetic Surgery

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: Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be 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 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 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: Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? 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.

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.

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

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	**$3,500**
Specialist visit copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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)

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$300
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6,500**

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

The plan's overall deductible	**$3,500**
Specialist visit copayment	**$100**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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)

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$2,400
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$6,040**

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

The plan's overall deductible	**$3,500**
Specialist visit copayment	**$100**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency Room Care (including medical supplies)
Diagnostic Test (x-ray)
Durable Medical Equipment (crutches)
Rehabilitation Services (physical therapy)

Total Example Cost	**$2,500**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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