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, visit www.starmarkinc.com or call 1-800-522-1246, ext. 26300. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-522-1246, ext. 26300 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0/individual $0/family Per Plan Year	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?	N/A	N/A
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?	$5,000/individual $10,000/family Per Plan Year	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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?	Pre-certification penalties, premiums, balanced-billing charges, and health care this plan doesn't cover.	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.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	$40 copay/office visit and 50% coinsurance for other outpatient services.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Telemedicine services via Teladoc® are available for $0 per consult.
If you visit a health care provider's office or clinic	Specialist visit	$40 copay/office visit and 50% coinsurance for other outpatient services.	
	Preventive care/screening/ immunization	No charge for covered services.	
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance, deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	$300 copay/procedure	$300 penalty for failure to precertify.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.starmarkinc.com	Generic drugs (Tier 1)	$20 copay/prescription (retail), $40 copay/prescription (mail order)	Covers up to a 30-day supply for a retail prescription; up to a 90 day supply for a mail order prescription.
	Preferred brand drugs (Tier 2)	$65 copay/prescription (retail), $160 copay/prescription (mail order)	Covers up to a 30-day supply for a retail prescription; up to a 90 day supply for a mail order prescription.
	Non-preferred brand drugs (Tier 3)	$95 copay/prescription (retail), $285 copay/prescription (mail order)	Covers up to a 30-day supply for a retail prescription; up to a 90 day supply for a mail order prescription.
	Specialty drugs (Tier 4)	$200 copay/prescription (retail)	Covers up to a 30-day supply. Use specialty pharmacy for in-network benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,500 access fee then 50% coinsurance	None
	Physician/surgeon fees	50% coinsurance	
	Emergency room care	$500 copay/visit	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency medical transportation	50% coinsurance	None
	Urgent care	$40 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 access fee then 50% coinsurance	$300 penalty for failure to precertify.
	Physician/surgeon fees	50% coinsurance	$300 penalty for failure to precertify.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance	40 visits/year, 120 visits while covered under this plan.
	Inpatient services	50% coinsurance	20 days/year, 40 days while covered under this plan. $300 penalty for failure to precertify.
If you are pregnant	Office Visits	0% coinsurance routine prenatal visits, 50% coinsurance other services	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	50% coinsurance	$300 penalty for failure to precertify.
If you need help recovering or have other special health needs	Home health care	50% coinsurance	100 days/year. $300 penalty for failure to precertify.
	Rehabilitation services	$40 copay/visit for Speech, Occupational and Physical therapy, 50% coinsurance for other services.	60 visits/year. Inpatient rehabilitation: $300 penalty for failure to precertify.
	Habilitation services	$40 copay/visit for Speech, Occupational and Physical therapy, 50% coinsurance for other services.	60 visits/year. Inpatient habilitation: $300 penalty for failure to precertify.
	Skilled nursing care	50% coinsurance	81 days/year. $300 penalty for failure to precertify.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	50% coinsurance	None
	Hospice services	50% coinsurance	6 months while covered under this plan. $300 penalty for failure to precertify.
If your child needs dental or eye care	Children's eye exam	Routine vision screening: No charge. Other services, including routine eye exam: Not covered.	None
	Children's glasses	Not covered	
	Children's dental check-up	Not covered	

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture (if prescribed for rehabilitation purposes), 12 visits per plan year
- Chiropractic care, 20 visits per plan year
- Private-duty nursing

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: 1-800-522-1246, ext. 26300 or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? **Yes**
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 1-800-522-1246, ext. 26300
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-522-1246, ext. 26300
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-522-1246, ext. 26300
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-522-1246, ext. 26300
----------*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 pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copay	$40
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$1,500
Copayments	$0
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	$0
Specialist copay	$40
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$0
Copayments	$2,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$2,850**

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

The plan's overall deductible	$0
Specialist copay	$40
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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