



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, see www.standish-sterling.org and/or call 1-989-846-3670. 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.cciio.cms.gov or call 1-800-999-0114 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | For network providers \$1,500 individual / \$3,000 family; for non-network providers \$3,000 individual / \$6,000 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 , urgent care and office visits and In and out of network emergency room treatment and prescription drugs are 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 or coinsurance 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 https://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 ? | For network providers \$5,500 individual / \$11,000 family; for non-network providers \$5,500 individual / \$11,000 family. The prescription drug out-of-pocket limit is: \$1,100 individual/ \$2,200 family. | 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 ? | Premiums , balance-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 ? | Yes. For providers see www.cofinity.net or call 1-800-831-1166 for a list of participating providers | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). |
| 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 |
|--|--|---|--|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$5 copay/visit | 20% coinsurance | None. |
| | Specialist visit | \$5 copay/visit | 20% coinsurance | None. |
| | Preventive care/screening/immunization | No charge | Not Covered | 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. Routine mammogram covered at 20% coinsurance non-network. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge after deductible | 20% coinsurance | None. |
| | Imaging (CT/PET scans, MRIs) | No charge after deductible | 20% coinsurance | None. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ehimrx.com . | Generic drugs | \$10 copay for retail and \$20 copay for mail order | 25% coinsurance after \$10 copay for retail and \$20 copay for mail order | Covers up to a 34 day supply (retail) or up to a 90 day supply (mail order). Deductible does not apply for non-network prescription drugs. |
| | Preferred brand drugs | \$20 copay for retail and \$40 copay for mail order | 25% coinsurance after \$20 copay for retail and \$40 copay for mail order | |
| | Non-preferred brand drugs | \$20 copay for retail and \$40 copay for mail order | 25% coinsurance after \$20 copay for retail and \$40 copay for mail order | |
| | Specialty Drugs | Generic Drugs-\$10 copay for retail and \$20 copay for mail order/Preferred brand/Non-Preferred Brand drugs \$20 copay for retail and \$40 copay for mail order | 25% coinsurance after: Generic Drugs-\$10 copay for retail and \$20 copay for mail order/Preferred brand/Non-Preferred Brand drugs \$20 copay for retail and \$40 copay for mail order | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge after deductible | 20% coinsurance | None. |
| | Physician/surgeon fees | No charge after deductible | 20% coinsurance | None. |



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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|---|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | \$250 copay/visit | \$250 copay/visit | Copay may be waived if admitted or accidental injury. |
| | Emergency medical transportation | No charge after deductible | No charge after Network deductible | In-network deductible applies for non-network services. |
| | Urgent care | \$20 copay/visit | 20% coinsurance | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge after deductible | 20% coinsurance | None. |
| | Physician/surgeon fees | No charge after deductible | 20% coinsurance | None. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$5 copay/visit | 20% coinsurance | None. |
| | Inpatient services | No charge after deductible | 20% coinsurance | None. |
| If you are pregnant | Office visits | \$5 copay/visit | 20% coinsurance. | Cost sharing does not apply for preventive services . Depending on the type of services, a [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 | No charge after deductible | 20% coinsurance | None. |
| | Childbirth/delivery facility services | No charge after deductible | 20% coinsurance | None. |
| If you need help recovering or have other special health needs | Home health care | No charge after deductible | Not Covered | None. |
| | Rehabilitation services | No charge after deductible | 20% coinsurance | Coverage is limited to a combined 60 visit maximum per plan year for occupational, physical therapy and speech therapy. |
| | Habilitation services | No charge after deductible | 20% coinsurance | Coverage is limited to a combined 60 visit maximum per plan year for occupational, physical therapy and speech therapy. |
| | Skilled nursing care | No charge after deductible | Not Covered | Coverage is limited to 90 days per plan year. |



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 |
|--|---|--|---|--|
| | | Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| | Durable medical equipment | No charge after deductible | No charge after Network deductible | In-network deductible applies to non-network services. |
| | Hospice services | No charge after deductible | Not Covered | Limited to 210 days per lifetime. Respite care limited to 5 days during a 30 day period. |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | None. |
| | Children's glasses | Not Covered | Not Covered | None. |
| | Children's dental check-up | Not Covered | Not Covered | None. |

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 | • Infertility treatment | • Routine eye care (Adult) |
| • Cosmetic surgery | • Long-term care | • Routine Foot Care |
| • Dental care (Adult) | • Most coverage provided outside the United States | • Weight loss programs |
| • Hearing Aids | • Non-emergency care when traveling outside the U.S. | |

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

- | | | |
|---------------------|---|------------------------|
| • Bariatric surgery | • Chiropractic care-limited to 24 visits in a 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: Department of Labor's Employee Benefits Security Administration at 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 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'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 1-800-999-0114.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-999-0114.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-999-0114.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-999-0114.

—————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 | \$1500 |
| ■ Specialist copayment | \$5 |
| ■ Hospital (facility) | 100% |
| ■ Other | 100% |

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 | \$1500 |
| Copayments | \$50 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1610 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|--------|
| ■ The plan's overall deductible | \$1500 |
| ■ Specialist copayment | \$5 |
| ■ Hospital (facility) | 100% |
| ■ Other | 100% |

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 | \$1500 |
| Copayments | \$620 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$2,175 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|--------|
| ■ The plan's overall deductible | \$1500 |
| ■ Specialist copayment | \$5 |
| ■ Hospital (facility) | 100% |
| ■ Other | 100% |

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 | \$1075 |
| Copayments | \$765 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1840 |