



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.starmarkinc.com](http://www.starmarkinc.com) or by calling 1-800-522-1246, option 7.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: \$2,500 person/\$5,000 family Out-of-network: \$5,000 person/\$10,000 family Does not apply to preventive care and prescription drugs. Copayments don't count toward the deductible.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes For in-network: \$1,000 person/\$2,000 family For out-of-network: \$4,000 person/\$8,000 family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Deductibles, copayments, access fees, pre-certification penalties, premium, balanced-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.

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Important Questions	Answers	Why this Matters:
Does this plan use a <u>network of providers</u> ?	Yes. For a list of <u>in-network providers</u> , see <a href="http://www.starmarkinc.com">www.starmarkinc.com</a> or call 1-800-522-1246, Option 7	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about <u>excluded services</u> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30/visit	40% coinsurance	Surgery at coinsurance.
	Specialist visit	\$30/visit	40% coinsurance	Surgery at coinsurance.
	Other practitioner office visit	20% coinsurance for other practitioners	40% coinsurance for other practitioners	Chiropractor - 20 visits/yr. Accupuncture, massage, naturopathic med, nutrition counseling - 12 visits/yr up to \$250 per visit.
	Preventive care/screening/immunization	No charge	40% coinsurance	none
If you have a test	Diagnostic test (x-ray, blood work)	100% to \$500	40% coinsurance	none
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	\$300 penalty for failure to precertify.

<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.starmarkinc.com">www.starmarkinc.com</a> .	Generic drugs	\$15 copay	Same as in-network	none
	Preferred brand drugs	\$45 copay	Same as in-network	none
	Non-preferred brand drugs	\$75 copay	Same as in-network	none
	Specialty drugs	\$45 copay or \$75 copay	Not covered	Higher copay for non-preferred drugs. Use specialty pharmacy for in-network benefit.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	none
	Physician/surgeon fees	20% coinsurance	40% coinsurance	none
<b>If you need immediate medical attention</b>	Emergency room services	\$200 copay/visit	Same as in-network	none
	Emergency medical transportation	20% coinsurance	Same as in-network	none
	Urgent care	\$60/visit	40% coinsurance	none
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	\$300 penalty for failure to precertify.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	\$300 penalty for failure to precertify.
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	40% coinsurance	50% coinsurance	40 visits/year, 120 visits/lifetime.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	20 days/year, 40 days/lifetime. N/A to alcohol abuse treatment. \$300 penalty for failure to precertify.
	Substance use disorder outpatient services	40% coinsurance	50% coinsurance	40 visits/year, 120 visits/lifetime.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	20 days/year, 40 days/lifetime. N/A to alcohol abuse treatment. \$300 penalty for failure to precertify.
<b>If you are pregnant</b>	Prenatal and postnatal care	20% coinsurance	40% coinsurance	none
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	\$300 penalty for failure to precertify.
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	40% coinsurance	100 days/year. \$300 penalty for failure to precertify.
	Rehabilitation services	20% coinsurance	40% coinsurance	60 visits/year. Inpatient rehabilitation: \$300 penalty for failure to precertify.
	Habilitation services	20% coinsurance	40% coinsurance	60 visits/year. Inpatient habilitation: \$300 penalty for failure to precertify.
	Skilled nursing care	20% coinsurance	40% coinsurance	81 days/year. \$300 penalty for failure to precertify.

	Durable medical equipment	20% coinsurance	40% coinsurance	none
	Hospice service	20% coinsurance	40% coinsurance	6 months/lifetime. \$300 penalty for failure to precertify.
If your child needs dental or eye care	Eye exam	No charge	Not covered	none
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Dental Care (Children)
- Most coverage provided outside of the United States
- Routine Eye Care (Children) - excluding eye exam
- Cosmetic surgery
- Hearing aids
- Non-emergency care when traveling outside of the United States
- Routine Foot Care
- Dental Care (Adult)
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purpose)
- Private-duty nursing
- Chiropractic care
- Infertility treatment

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-522-1246, option 7. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).



## **Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-800-522-1246, option 7.

If your plan is subject to ERISA you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/cbsa/healthreform](http://www.dol.gov/cbsa/healthreform).

## **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-522-1246, option 7.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-522-1246, option 7.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-522-1246, option 7.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-522-1246, option 7.

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

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,020
- Patient pays \$3,520

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$2,500
Copays	\$20
Coinsurance	\$800
Limits or exclusions	\$200
<b>Total</b>	<b>\$3,520</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,000
- Patient pays \$2,400

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$2,300
Coinsurance	\$0
Limits or exclusions	\$100
<b>Total</b>	<b>\$2,400</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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