Summary of Bene ts and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2023 to 12/31/2023

Staff Bene ts Management & Administrators: Minimum Value PPO Plan

Coverage for: Eligible Employees and Eligible Dependents | **Plan Type:** Minimum Value Reference-Based Pricing

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 1-888-505-7724. 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.dol.gov/ebsa/healthreform or call 1-888-505-7724 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	You do not need to meet any deductible before the plan pays for covered services.
Are there other deductibles for specific services?	Not Applicable	No there is no deductible to meet for any covered services.
What is the out-of-pocket limit for this plan?	$7,150 individual / $14,300 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 is reached.
Will you pay less if you use a network provider?	Not Applicable	You must use a network provider. There is no coverage for out-of-network providers.
Will you pay more if you use an out-of-network provider?	Yes. Visit www.multiplan.com/sbmapa or call 1-800-454-5231 for a list of network providers.	This plan uses a provider network. You will pay 100% of the cost for services if you use an out-of-network provider. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

* For more information about limitations and exceptions, call 1-888-505-7724

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	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	$15 copay	Not covered	None.
	Specialist visit	$15 copay	Not covered	None.
	Preventive care/screening/ immunization	$0	Not covered	With respect to all preventive services provided under the plan, if a recommendation or guideline for a service frequency, method, treatment or setting for the service, the plan will use reasonable medical management techniques to determine coverage limitations. You may have to pay for services that are not preventive services. Ask your provider if the services needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$0 for preventive blood work, otherwise $50 copay	Not covered	Maternity–related diagnostic tests are not covered.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not covered	No coverage for advanced imaging.

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.mysmtihrx.com**	Generic drugs	$0 for preventive drugs otherwise $40 copay	Not covered	Non-preferred brand and specialty prescription drugs are excluded. Generic prescription drugs have a $40 copay and limited to a 30-day supply. If no generic options is available, preferred brand drugs have a $60 copay and limited to a 30-day supply. Prescription drugs that are considered preventive are provided free of charge but may or may not be subject to coverage limitations. Ask your provider if the prescription drugs needed are preventive, then check what your plan will pay for.
	Preferred brand drugs	If no generic option is avaialble, $60 copay	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	No coverage for facility fee (e.g., ambulatory surgery center).
	Physician/surgeon fees	Not covered	Not covered	No coverage for physician / surgeon fees.
If you need immediate medical attention	Emergency room care	$400 copay, then any amount exceeding 125% of the Medicare allowable payment	Not covered	Member will be balance billed for any costs exceeding 125% of the Medicare allowable payment. Balance-billing charges do not count toward the out-of-pocket limit.
	Emergency medical transportation	Not covered	Not covered	No coverage for emergency medical transportation
	Urgent care	$50 copay	Not covered	None.

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Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay, then 20% coinsurance (plan pays 80%) of Medicare allowable payment not to exceed 125%.	Not covered	Member will be balance billed for any costs exceeding 125% of the Medicare allowable payment. Balance-billing charges do not count toward the out-of-pocket limit. Preauthorization is required for any non-emergency surgery; failure to obtain preauthorization will result in a $250 penalty or a denial of coverage.
	Physician/surgeon fees	$1,000 copay, then 20% coinsurance (plan pays 80%) of Medicare allowable payment not to exceed 125%.	Not covered	
If you need mental health, behavioral health, or substance	Outpatient services	Not covered	Not covered	No coverage for outpatient services.
	Inpatient services	Not covered	Not covered	No coverage for inpatient services.
If you are pregnant	Office visits	$15 copay	Not covered	Coverage is limited to covered members and covered member spouses only; not dependent children.
	Childbirth/delivery professional services	Not covered	Not covered	No coverage for childbirth / delivery professional services.
	Childbirth/delivery facility services	$1,000 copay, then 20% coinsurance (plan pays 80%) of Medicare allowable payment not to exceed 125%.	Not covered	Coverage is limited to covered members and covered member spouses only; not dependent children. Member will be balance billed for any costs exceeding 125% of the Medicare allowable payment. Balance-billing charges do not count toward the out-of-pocket limit. Preauthorization is required for any non-emergency surgery; failure to obtain preauthorization will result in a $250 penalty or a denial of coverage.

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage for home health care.
	Rehabilitation services	Not covered	Not covered	No coverage for rehabilitation services.
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	Not covered	Not covered	No coverage for skilled nursing care.
	Durable medical equipment	Not covered	Not covered	No coverage for durable medical equipment.
	Hospice services	Not covered	Not covered	No coverage for hospice services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for children's eye exam.
	Children's glasses	Not covered	Not covered	No coverage for children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for children's dental check-up.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

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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	Dental Care (Adult)	Private-duty nursing
Bariatric Surgery	Hearing Aids	Routine Eye Care (Adult)
Care when traveling outside the US	Infertility Treatment	Routine Foot Care
Chiropractic Care Cosmetic Surgery	Long-Term Care	Weight Loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
None

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: the 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: 1-888 -505-7724 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ or you may contact 1-888-505-7724 for more information.

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? **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 1-888-505-7724)
(Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-505-7724)
(Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-505-7724)
(Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-505-7724)

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

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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 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)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
The plan's overall deductible	**$0**	**The plan's overall deductible**	**$0**	**The plan's overall deductible**	**$0**
Specialist copay	**N/A**	**Primary care copay**	**$15**	**Emergency Room copay**	**$400**
Hospital (facility)	**$1000/20 %**	**Specialty prescription drugs**	**N/A**	**X-ray copay**	**$50**
Other cost sharing	**Varies**	**Other cost sharing**	**Varies**	**Other cost sharing**	**Varies**
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)*		**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)		**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	**$12,800**	**Total Example Cost**	**$4,500**	**Total Example Cost**	**$7,200**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$0	Deductibles	$0	Deductibles	$0
Copayments	$1,000	Copayments	$90	Copayments	$600
Coinsurance	$1,600	Coinsurance	N/A	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$3,500	Limits or exclusions	$2,900	Limits or exclusions	$3,300
The total Peg would pay is	**$6,100**	**The total Joe would pay is**	**$2,990**	**The total Mia would pay is**	**$3,900**

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

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