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.polestarbenefits.com or by calling 855-222-3358. You can get a copy of the Uniform Glossary at www.dol.gov/ebsa/healthreform.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	See Health Plan	Not applicable
Are there other deductibles for specific services?	None	You don't have to meet **deductibles** for specific services to be eligible for payment.
Is there an out–of–pocket limit on my expenses?	No.	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services. This plan will only pay up to the amount elected by the employee and what is contributed by the employer.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket** limit.	Not applicable because there's no **out-of-pocket** limit on your expenses under this FSA plan, but see the health plan summary for an **out-of-pocket** limit under that plan. This plan pays up to the employee annual election, plus the employer contribution.
Is there an overall annual limit on what the plan pays?	Yes. The plan pays up to the employee elected amount, plus your employer makes additional contributions based on your employee "group" that can be used for plan payment as well.	In addition to amount elected by the Employee and contributed through payroll, the Employer also contributes based on each employee group (the amounts are shown below) increasing the total amount the Employee may be reimbursed for eligible expenses *with a minimum annual employee election of $240 to the health care FSA:* Faculty $150 for those enrolled in employee only insurance $250 for those enrolled in employee + spouse or employee + children insurance $300 for those enrolled in full family insurance Management - Completion of Health Risk Assessment Required (monitored by LCC HR Staff) $150 for those enrolled in employee only insurance $250 for those enrolled in employee + 1 insurance $300 for those enrolled in full family insurance

		Classified - Completion of Health Risk Assessment Required (monitored by LCC HR Staff) $450 for those enrolled in employee only insurance $850 for those enrolled in employee + 1 insurance $1100 for those enrolled in full family insurance This plan covers expenses that are applied to section 213d of the IRS code. These eligible expenses are ones that are used to treat, maintain or mitigate a specific medical, dental or vision condition. General health items (like multi-vitamins) are not eligible.
Does this plan use a network of providers?	No.	This plan treats **providers** the same in determining payment for the services, however the amount paid by this plan will depend on amount elected by the employee, plus the employer contribution and the amount of eligible expenses incurred in the coverage period.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan, but a referral may be required under the health plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**, if any.
- 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**.)
- Your cost-sharing does not depend on whether the provider is in a network.

Common Medical Event	Services You May Need	Your cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	See the health plan	See overall health plan benefit that pays medical expenses. This plan covers out-of-pocket expenses that are eligible under section 213d of the IRS code and as such could be reimbursed up to. Eligible expenses are ones that are used to treat, maintain or mitigate a specific medical, dental or vision condition. General health items (like multi-vitamins) are not eligible.
	Specialist visit	See the health plan	
	Other practitioner office visit	See the health plan for chiropractor & for acupuncture.	
	Preventive care/screening/immunization	See the health plan	
If you have a test	Diagnostic test (x-ray, blood work)	See the health plan	See overall health plan benefit that pays medical expenses. This plan covers out-of-pocket expenses that are eligible under section 213d of the IRS code and as such could be reimbursed up to . Eligible expenses are ones that are used to treat, maintain or mitigate a specific medical, dental or vision condition. General health items (like multi-vitamins) are not eligible.
	Imaging (CT/PET scans, MRIs)	See the health plan	

Common Medical Event	Services You May Need	Your cost	Limitations & Exceptions
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** see the health plan SBC	Generic drugs	Retail See the health plan Mail Order See the health plan	See overall health plan benefit that pays medical expenses. This plan covers out-of-pocket expenses that are eligible under section 213d of the IRS code and as such could be reimbursed up to . Eligible expenses are ones that are used to treat, maintain or mitigate a specific medical, dental or vision condition. General health items (like multi-vitamins) are not eligible.
	Preferred brand drugs	Retail See the health plan Mail Order See the health plan	
	Non-preferred brand drugs	Retail See the health plan Mail Order See the health plan	
	Specialty drugs	See the health plan	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See Health Plan	
	Physician/surgeon fees	See Health Plan	
If you need immediate medical attention	Emergency room services	See Health Plan	
	Emergency medical transportation	See Health Plan	
	Urgent care	See Health Plan	
If you have a hospital stay	Facility fee (e.g., hospital room)	See Health Plan	
	Physician/surgeon fee	See Health Plan	

Common Medical Event	Services You May Need	Your cost	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	See Health Plan	See overall health plan benefit that pays medical expenses. This plan covers out-of-pocket expenses that are eligible under section 213d of the IRS code and as such could be reimbursed up to . Eligible expenses are ones that are used to treat, maintain or mitigate a specific medical, dental or vision condition. General health items (like multi-vitamins) are not eligible.
	Mental/Behavioral health inpatient services	See Health Plan	
	Substance use disorder outpatient services	See Health Plan	
	Substance use disorder inpatient services	See Health Plan	
If you are pregnant	Prenatal and postnatal care	See Health Plan	
	Delivery and all inpatient services	See Health Plan	
If you need help recovering or have other special health needs	Home health care	See Health Plan	
	Rehabilitation services	See Health Plan	
	Habilitation services	See Health Plan	
	Skilled nursing care	See Health Plan	
	Durable medical equipment	See Health Plan	
	Hospice service	See Health Plan	
If your child needs dental or eye care	Eye exam	See Health Plan	
	Glasses	See Health Plan	
	Dental check-up	See Health Plan	

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.)

- Any service not defined as includible by section 213d or IRS Publication 502

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.)**
• Not Applicable

Your Rights to Continue Coverage:

**** Group health coverage sample –**

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**. Other limitations on your rights to continue coverage may also apply.

OR

For more information on your rights to continue coverage, contact the plan at {541-463-5589}. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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: Darcy Dillon. You can also contact the department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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:** $30,000.00
- **This Plan pays up to annual election maximum of section 213d expenses.**
- **Patient pays the other Health Plan Expenses.**

Sample care costs:

Hospital charges (mother)	See Health Plan
Routine obstetric care	See Health Plan
Hospital charges (baby)	See Health Plan
Anesthesia	See Health Plan
Laboratory tests	See Health Plan
Prescriptions	See Health Plan
Radiology	See Health Plan
Vaccines, other preventive	See Health Plan
Total	**See Health Plan**

Patient pays:

Deductibles	See Health Plan
Co-pays	See Health Plan
Co-insurance	See Health Plan
Limits or exclusions	See Health Plan
Total	**See Health Plan**

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

Amount owed to providers: $50,000.00

- **This Plan pays up to annual election maximum of section 213d expenses.**
- **Patient pays the other Health Plan Expenses.**

Sample care costs:

Prescriptions	See Health Plan
Medical Equipment and Supplies	See Health Plan
Office Visits and Procedures	See Health Plan
Education	See Health Plan
Laboratory tests	See Health Plan
Vaccines, other preventive	See Health Plan
Total	**See Health Plan**

Patient pays:

Deductibles	See Health Plan
Co-pays	See Health Plan
Co-insurance	See Health Plan
Limits or exclusions	See Health Plan
Total	**See Health Plan**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.