**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services
**Solo Health – V5000**

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, contact Solo Health at solo.health or 646-328-6968, or Vault Admin Services at www.allthingsvault.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary at www.cciio.cms.gov or call 1-877-424-2366 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$5,000** individual / **$10,000** family | Generally, you must pay all 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. Preventive care and $0 preventive medications are covered at 100% with the deductible waived, and telehealth visits are covered at 100% before you meet your deductible. Preventive care follows ACA preventive-care guidelines. | This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment may apply. |
| **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 | 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?** | Certain drug coupon amounts, premiums, balance billing charges, & non-covered excluded services. | 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?** | This plan uses the MultiPlan PHCS Practitioner & Ancillary network (a Claritev network). See providersearch.multiplan.com for a list of network providers. | Your deductible and out-of-pocket maximum are the same in and out of network. Out-of-network services are covered subject to reference-based pricing, and you may be responsible for amounts a provider charges above the plan's allowable amount (balance billing). Emergency services are always treated as in-network. |
| **Do you need a referral to see a specialist?** | No. | You can see a specialist 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 |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | After Deductible, plan pays 100% | None |
| | Specialist visit | After Deductible, plan pays 100% | None |
| | Preventive care/screening/immunization | 100% deductible waived | Preventive care follows ACA guidelines (USPSTF A/B, ACIP immunizations, and HRSA guidelines); see www.healthcare.gov/preventive-care-benefits. You may have to pay for services that aren't preventive — ask your provider whether a service is preventive. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | After Deductible, plan pays 100% | None |
| | Imaging (CT/PET scans, MRIs) | After Deductible, plan pays 100% | Prior authorization required for advanced imaging. |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available from FairosRx (833-464-9600) | **Tier:** | **Retail (30-day) / Mail order (90-day)** | Certain limitations may apply including prior authorization requirements, step therapy rules, and certain quantity limits. Only medications on the Solo Rx Formulary are covered. |
| | Tier 1: Preventive Drugs | $0.00 (prior to and after meeting the deductible) | |
| | Tier 2: Preferred Generics | 100% prior to meeting deductible; $15.00 retail / $30.00 mail order copay after deductible | |
| | Tier 3: Preferred Brand & Non-Preferred Generics | 100% prior to meeting deductible; $50.00 retail / $100.00 mail order copay after deductible | |
| | Tier 4: Non-Preferred Brand | 100% prior to meeting deductible; $100.00 retail / $200.00 mail order copay after deductible | |
| | Tier 5: Specialty Drugs | $0 copay up to $1,000 per prescription after deductible; the member is responsible for prescription costs exceeding $1,000 per fill | |
| | Tier 6: Non-Formulary & Excluded Drugs | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | After Deductible, plan pays 100% | Prior authorization required. |
| | Physician/surgeon fees | After Deductible, plan pays 100% | None |
| **If you need immediate medical attention** | Emergency room care | After Deductible, plan pays 100% | Always treated as in-network. |
| | Emergency medical transportation | After Deductible, plan pays 100% | Emergent/Non-Emergent Air Ambulance – $15,000 Maximum Benefit per Flight |
| | Urgent care | After Deductible, plan pays 100% | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | After Deductible, plan pays 100% | Prior authorization required. |
| | Physician/surgeon fees | After Deductible, plan pays 100% | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | After Deductible, plan pays 100% | Mental health office visits limited to 40 visits per calendar year. Prior authorization required for outpatient treatment programs. |
| | Inpatient services | After Deductible, plan pays 100% | Prior authorization required. |
| **If you are pregnant** | Office visits | After Deductible, plan pays 100% | None |
| | Childbirth/delivery professional services | After Deductible, plan pays 100% | None |
| | Childbirth/delivery facility services | After Deductible, plan pays 100% | None |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | After Deductible, plan pays 100% | Limited to 40 visits per calendar year. Prior authorization required. |
| | Rehabilitation services | After Deductible, plan pays 100% | Limited to 40 visits per calendar year |
| | Habilitation services | After Deductible, plan pays 100% | Limited to 40 visits per calendar year |
| | Skilled nursing care | After Deductible, plan pays 100% | Prior authorization required. |
| | Durable medical equipment | After Deductible, plan pays 100% | Prior authorization required for DME over $1,500 purchase or rentals over $500/month. |
| | Prosthetics | After Deductible, plan pays 100% | Lifetime maximum benefit $5,000. |
| Hospice services | After Deductible, plan pays 100% | One benefit period not to exceed 6 months. Prior authorization required. | |
| **If your child needs dental or eye care** | Children's Eye Exam | No Charge | None |
| | Children's glasses | Not covered | None |
| | Children's dental check-up | 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.) | | |
|---|---|---|
| • Cosmetic Surgery<br>• Dental Care (Adult)<br>• Bariatric Surgery<br>• Acupuncture | • Long-Term Care<br>• Private-duty nursing<br>• Infertility treatment | • Routine foot or eye care (adults)<br>• Weight loss programs<br>• Non-Emergency care outside U.S. |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Chiropractic Care (40 visits per calendar year) | • Hearing Aids | • Telehealth (plan pays 100%, deductible waived) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. Other coverage options may be available to you, too, including continuation of coverage under COBRA or applicable state continuation law as described in the plan's Summary Plan Description, or buying individual 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 on how 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: Vault Admin Services, Attention: Appeals, 4022 E. Greenway, Ste. 11-12, Phoenix, AZ 85022 | 877-424-2366.

**Does this plan provide Minimum Essential Coverage?** Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**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.

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

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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**<br>(9 months of in-network pre-natal care and a hospital delivery) | |
|---|---|
| The plan's overall deductible | **$5,000** |
| Specialist [copay] | **$0** |
| Hospital (facility) [coinsurance] | **0%** |
| Other [coinsurance] | **0%** |
| **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** | **$12,731** |
| Deductibles | **$5,000** |
| Copayments | **$0** |
| Coinsurance | **$0** |
| Limits or exclusions | **$0** |
| **The total Peg would pay is** | **$5,000** |

| **Managing Joe's Type 2 Diabetes**<br>(a year of routine in-network care of a well-controlled condition) | |
|---|---|
| The plan's overall deductible | **$5,000** |
| Specialist [copay] | **$0** |
| Hospital (facility) [coinsurance] | **0%** |
| Other [coinsurance] | **0%** |
| **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** | **$7,389** |
| Deductibles | **$5,000** |
| Copayments | **$0** |
| Coinsurance | **$0** |
| Limits or exclusions | **$0** |
| **The total Joe would pay is** | **$5,000** |

| **Mia's Simple Fracture**<br>(in-network emergency room visit and follow up care) | |
|---|---|
| The plan's overall deductible | **$5,000** |
| Specialist [copay] | **$0** |
| Hospital (facility) [coinsurance] | **0%** |
| Other [coinsurance] | **0%** |
| **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** | **$1,925** |
| Deductibles | **$1,925** |
| Copayments | **$0** |
| Coinsurance | **$0** |
| Limits or exclusions | **$0** |
| **The total Mia would pay is** | **$1,925** |

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