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 Planstin Member Services at 888-920-7526. For general definitions of common terms, or other underlined terms, see the **Uniform Glossary.**

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**	All covered services are based on a Copay, percentage of cost or in-network rate, up to the visit and Plan limits.
Are there other Deductible for specific services?	**No**	This Plan does not have a Deductible.
What is the Out-of-Pocket Limit for this Plan?	**Not Applicable**	This Plan does not have an Out-of-Pocket Limit on your expenses.
What is not included in the Out-of-Pocket Limit?	**Not Applicable**	This Plan does not have an Out-of-Pocket Limit on your expenses.
Will you pay less if you use a Network Provider?	**Yes. See the PHCS Website or call 800-922-4362 for a list of Network Providers.**	This Plan uses the PHCS 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). Be aware, your Network Provider might use an Out-of-Network Provider for some services. Check with your Provider before you get services.
Are there Prescription Services?	**Yes**	Prescription services available through OptumRx. The pharmacy help desk can be reached at 877-633-4461. Start using all features of your prescription card by going to the OptumRx Portal.
Do you need a Referral to see a Specialist?	**No**	You can see the Specialist you choose without a Referral.

[* For more information about limitations and exceptions, see the plan or policy document at planstin.com/resources.]

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'll Pay the Least)	Out-of-Network Provider (You'll Pay the Most)	
If you visit a health care Provider's office or clinic	Primary Care Visit to Treat an Injury or Illness	$20 copay/visit	$50 copay/visit	Plan pays for a max of 5 visits per plan year. Plan pays a max of $150 per visit.
	Specialist Visit	$50 copay/visit	$100 copay/visit	Plan pays for a max of 5 visits per plan year. Plan pays a max of $300 per visit.
	Preventive Care / Screening / Immunization	No charge	Not covered	Preventive services are required to be in-network with PHCS.
If you have a test	Diagnostic Test (X-Ray)	$50 copay/x-ray	$100 copay/x-ray	Plan pays for a max of 5 diagnostic x-rays per plan year. Plan pays a max of $250 per x-ray.
	Lab/Bloodwork	$10 copay/lab	$25 copay/lab	Plan pays for a max of 10 labs per plan year. Plan pays a max of $100 per lab.
	Imaging (MRI, CT/PET Scans, Ultrasounds)	$200 copay/test	$400 copay/test	Plan pays for a max of 2 imaging services per plan year. Plan pays a max of $1,000 per test.
If you need drugs to treat your illness or condition More information about Prescription Drug discounts is available at rx.planstin.com	Tier 1 - Generic	$10 Copay	Not Covered	Plan pays up to a maximum of $150 per RX
	Tier 2 - Preferred Brand	$25 Copay	Not Covered	Plan pays up to a maximum of $150 per RX
	Tier 3 - Non-Preferred Brand	$50 Copay	Not Covered	Plan pays up to a maximum of $150 per RX
	Tier 4 – Specialty	Excluded	Not covered	May be excluded from coverage or subject to prior authorization.
If you have outpatient surgery	Facility Fee / ASC	Not Covered	Not Covered	
	Physician/Surgeon Fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency Room Care	Not Covered	Not Covered	
	Emergency Medical Transport	Not Covered	Not Covered	
	Urgent Care	$50 Copay/Visit	$100 Copay/Visit	Plan pay for a max of 5 urgent care visits per plan year. Plan pays a max of $300 per visit.

[* For more information about limitations and exceptions, see the plan or policy document at planstin.com/resources.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You'll Pay the Least)	Out-of-Network Provider (You'll Pay the Most)	
If you have a hospital stay	Facility Fee (i.e., Hospital Room)	Not Covered	Not Covered	
	Physician/Surgeon Fees	Not Covered	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	Not Covered	Not Covered	
	Inpatient Services	Not Covered	Not Covered	
If you are pregnant	Office Visits (Specialist)	$50 Copay/Visit	$100 Copay/Visit	Copays apply to Specialist visit copay limit. Plan pays for a max of 5 visits per plan year. Plan pays a max of $300 per visit.
	Childbirth / Delivery Professional Services	Not Covered	Not Covered	
	Childbirth / Delivery Facility Services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home Health Care	Not Covered	Not Covered	
	Rehabilitation Services	Not Covered	Not Covered	
	Habilitation Services	Not Covered	Not Covered	
	Skilled Nursing Care	Not Covered	Not Covered	
	Durable Medical Equipment	Not Covered	Not Covered	
	Hospice Services	Not Covered	Not Covered	
If your child needs dental or eye care	Children's Vision Acuity Screening	No Charge*	Not Covered**	*Preventive services are required to be in-network with PHCS. **Out-of-Network Preventive Care is not covered under this health plan.
	Children's Glasses	Not Covered	Not Covered	
	Children's Fluoride Varnish	No Charge*	Not Covered**	*Preventive services are required to be in-network with PHCS. **Out-of-Network Preventive Care is not covered under this health plan.

[* For more information about limitations and exceptions, see the plan or policy document at planstin.com/resources.]

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
- Adult Dental Care
- Adult Vision Care
- Anesthetic
- Bariatric Surgery
- Cancer
- Chiropractic Manipulative Treatment
- Durable Medical Equipment
- Emergency Room Services
- Essure
- Hospital Admission or Facility
- Infertility Treatment
- Inpatient or Outpatient Surgery
- Labor & Delivery
- Long Term Care
- Major diagnostic tests
- Mental health
- Pathology Services
- Physical or Occupational Therapy
- Tubal Ligation
- Vasectomy

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your Plan document.)

- All covered services are limited by number allowed per plan year and maximum payable amount, per visit/lab/test.
- Preventive services/care are required to be in-network with PHCS. Out-of-network preventive care is not covered.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To continue coverage after it ends, contact: Planstin Member Services at 888-920-7526 or member@planstin.com. Other options to continue coverage are 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 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: Planstin Member Services at 888-920-7526 or member@planstin.com.

Does this plan provide Minimum Essential Coverage? YES

If you do not have Minimum Essential Coverage for a month, you will 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 does not meet the Minimum Value Standards, you may be eligible for a Premium Tax Credit to help you pay for a plan through the Marketplace.

Out of Network Claims Processing:

Except as otherwise required under state or Federal regulations, the maximum amount the plan is obligated to pay for services provided by a non-primary PPO provider will be the lesser of the provider's billed charges for covered services and an amount determined by one or more of the following, which we may sometimes modify to maintain the reasonableness of the Allowed Amount:

- Using current publicly available data reflecting fees typically reimbursed to providers for the same or similar professional services, adjusted for geographical differences where applicable.
- Using amounts calculated based on what Medicare would reimburse for the services billed.
- Using the rates negotiated with the provider for all services provided under a non-primary network contract or claim-specific agreement.

[* For more information about limitations and exceptions, see the plan or policy document at planstin.com/resources.]

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	**$0**
Specialist Visit Copay	**$50**
Imaging Copay	**$200**
Lab Copay	**$10**
Hospital (Facility) ***[Not Covered]***	**0%**

This EXAMPLE event includes services like:

Specialist Office Visits (*Prenatal Care) x5*
Diagnostic Tests (*Ultrasounds) x2*
Diagnostic Tests (*Bloodwork Labs) x10*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services *(Including Anesthesia)*

Total Example Cost	**$6,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$750
Coinsurance	$0
What is NOT Covered	
Limits or Exclusions	$3,000
The total Peg would pay is	**$3,750**

Managing Joe's Type 2 Diabetes
(A Year of Routine In-Network Care of a Well-Controlled Condition)

The Plan's Overall Deductible	**$0**
Primary Care Visit Copay	**$20**
Tier 2 Rx Copay	**$25**
Lab Copay	**$10**
Durable Medical Equipment ***[Not Covered]***	**0%**

This EXAMPLE event includes services like:

Primary Care Physician Office Visits (*Including Disease Education) x2*
Diagnostic Tests *(Bloodwork Labs) x5*
Prescription Drugs *(Monthly) x12*
Durable Medical Equipment *(Glucose Meter)*

Total Example Cost	**$1,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$390
Coinsurance	$0
What is NOT Covered	
Limits or Exclusions	$350
The total Joe would pay is	**$740**

Mia's Simple Fracture
(In-Network Emergency Room Visit and Follow Up Care)

The Plan's Overall Deductible	**$0**
Specialist Copay	**$50**
ER Facility Services ***[Not Covered]***	**0%**
Durable Medical Equipment ***[Not Covered]***	**0%**

This EXAMPLE event includes services like:

Rehabilitation Specialist Services *(Physical Therapy) x5*
Emergency Room Care *(Including Supplies)*
Emergency Room Diagnostic Test *(X-Ray)*
Durable Medical Equipment *(Crutches)*

Total Example Cost	**$3,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$250
Coinsurance	$0
What is NOT Covered	
Limits or Exclusions	$2,000
The total Mia would pay is	**$2,250**

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