




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's Member Service 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 <a href="#">Deductible</a> ?	\$3,000/Individual \$6,000/Family	Generally, you must pay all of the costs from <a href="#">Providers</a> up to the <a href="#">Deductible</a> amount before this <a href="#">Plan</a> begins to pay. If you have other family members on the <a href="#">Plan</a> , the overall family <a href="#">Deductible</a> must be met before the <a href="#">Plan</a> begins to pay.
Are there services covered before you meet your <a href="#">Deductible</a> ?	Yes	This <a href="#">Plan</a> covers <a href="#">Preventive Services</a> even if you haven't yet met the <a href="#">Deductible</a> amount, as long as <a href="#">Preventive Services</a> are obtained from an in-network provider.
Are there other <a href="#">Deductibles</a> for specific services?	No	Not applicable
What is the <a href="#">Out-of-Pocket Limit</a> for this <a href="#">Plan</a> ?	\$6,500/Individual \$13,000/Family	The <a href="#">Out-of-Pocket Limit</a> is the most you could pay in a year for covered services. If you have other family members on this <a href="#">Plan</a> , the overall family <a href="#">Out-of-Pocket Limit</a> must be met.
What is not included in the <a href="#">Out-of-Pocket Limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">Premiums</a> , <a href="#">Balance Billing</a> charges, and health care this <a href="#">Plan</a> doesn't cover.	Even though you pay these expenses, they don't count towards the <a href="#">Out-of-Pocket Limit</a> .
Will you pay less if you use a <a href="#">Network Provider</a> ?	Yes. See the <a href="#">PHCS Website</a> or call 800-922-4362 for a list of <a href="#">Network Providers</a>	This <a href="#">Plan</a> uses a provider <a href="#">Network</a> . You will pay less if you use a <a href="#">Provider</a> in the plan's <a href="#">Network</a> . You will pay the most if you use an <a href="#">Out-of-Network Provider</a> and you might receive a bill from a <a href="#">Provider</a> for the difference between what the <a href="#">Provider</a> charges and what your <a href="#">Plan</a> pays ( <a href="#">Balance Billing</a> ).
Are there prescription services?	Yes, Prescription Discounts	Prescription discounts 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 <a href="#">OptumRx Portal</a> .
Do you need a <a href="#">Referral</a> to see a <a href="#">Specialist</a> ?	No	You can see the <a href="#">Specialist</a> you choose without a <a href="#">Referral</a> .

 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 <a href="#">Provider's office or clinic</a>	<a href="#">Primary Care</a> Visit to Treat an Injury or Illness	\$35 Copay/Visit <b>AFTER</b> deductible is met.	Not Covered**	<a href="#">Copay</a> with <a href="#">Network Provider</a> applies after deductible is met. ** <a href="#">Out-of-Network</a> visits will not apply to deductible.
	<a href="#">Specialist</a> Visit	\$60 Copay/Visit <b>AFTER</b> deductible is met.	Not Covered	<a href="#">Copay</a> with <a href="#">Network Provider</a> applies after deductible is met. ** <a href="#">Out-of-Network</a> visits will not apply to deductible.
	<a href="#">Preventive Care/Screening/Immunization</a>	No Charge*	Not Covered**	<a href="#">Preventive services</a> are required to be in-network with PHCS. <a href="#">Out-of-Network Preventive Care</a> is not covered under this health plan.
If you have a test	<a href="#">Diagnostic Test</a> (X-Ray)	Not Covered	Not Covered	
	Lab/Bloodwork	\$10 Copay/Lab <b>AFTER</b> deductible is met.	Not Covered**	<a href="#">Copay</a> with <a href="#">Network Provider</a> applies after deductible is met. ** <a href="#">Out-of-Network</a> labs will not apply to deductible.
	Imaging (MRI, CT/PET Scans, Ultrasounds)	Not Covered	Not Covered	
If you need drugs to treat your illness or condition More information about <a href="#">Prescription Drug discounts</a> is available at <a href="#">rx.planstin.com</a>	Tier 1 - Generic	Check Discount Card	Not Covered	Check <a href="#">rx.planstin.com</a> for More Information
	Tier 2 - Preferred Brand	Check Discount Card	Not Covered	Check <a href="#">rx.planstin.com</a> for More Information
	Tier 3 - Non-Preferred Brand	Check Discount Card	Not Covered	Check <a href="#">rx.planstin.com</a> for More Information
If you have outpatient surgery	Facility fee (i.e., ASC)	Not Covered	Not Covered	
	Physician/Surgeon Fees	Not Covered	Not Covered	
If you need immediate medical attention	<a href="#">Emergency Room Care</a>	Not Covered	Not Covered	
	<a href="#">Emergency Medical Transportation</a>	Not Covered	Not Covered	
	<a href="#">Urgent Care</a>	Not Covered	Not Covered	

[\* 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 Visit	\$60 Copay/Visit <b>AFTER</b> deductible is met.	Not Covered**	Applies to specialist visits. <a href="#">Copay</a> with <a href="#">Network Provider</a> applies after deductible is met. <b>**Out-of-Network</b> visits will not apply to deductible.
	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	<a href="#">Home Health Care</a>	Not Covered	Not Covered	
	<a href="#">Rehabilitation Services</a>	Not Covered	Not Covered	
	<a href="#">Habilitation Services</a>	Not Covered	Not Covered	
	<a href="#">Skilled Nursing Care</a>	Not Covered	Not Covered	
	<a href="#">Durable Medical Equipment</a>	Not Covered	Not Covered	
	<a href="#">Hospice Services</a>	Not Covered	Not Covered	
If your child needs dental or eye care	Children's Vision Acuity Screening	No Charge*	Not Covered**	<a href="#">*Preventive Services</a> are required to be in-network with PHCS. <b>**Out-of-Network Preventive Care</b> is not covered under this health plan.
	Children's Glasses	Not Covered	Not Covered	
	Children's Fluoride Varnish	No Charge*	Not Covered**	<a href="#">*Preventive Services</a> are required to be in-network with PHCS. <b>**Out-of-Network Preventive Care</b> is not covered under this health plan.

[\* For more information about limitations and exceptions, see the plan or policy document at [planstin.com/resources](http://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                  | • Durable Medical Equipment            | • Inpatient or Outpatient Surgery |
| • Adult Dental Care            | • Emergency Room Services              | • Labor and Delivery              |
| • Adult Vision Care            | • Essure                               | • Long Term Care                  |
| • Anesthetic                   | • Genetic Testing / Genomic Sequencing | • Pathology Services              |
| • Bariatric Surgery            | • Home Health Care / Hospice           | • Tubal Ligation                  |
| • Cancer                       | • Hospital Admission or Facility       | • Urgent Care Office Visits       |
| • Diagnostic X-rays or Imaging | • Infertility Treatment                | • Vasectomy                       |

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

- Preventive services/care are required to be in-network with PHCS. Out-of-network preventive care is not covered.
- In-network primary care visits, in-network specialist visits, and in-network labs would apply to the deductible. Out of network care will not apply to the deductible.
- In-network primary care visits, in-network specialist visits, and in-network labs count toward the out-of-pocket limit. Out of network care will not count towards the out-of-pocket limit.

**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](mailto: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](http://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](mailto: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.

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

## 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	\$3,000
■ Specialist Visit Copay [ <i>Deductible Not Met</i> ]	\$0
■ Imaging Copay [ <i>Not Covered</i> ]	\$0
■ Lab Copay [ <i>Deductible Not Met</i> ]	\$0
■ Hospital (Facility) [ <i>Not Covered</i> ]	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*)

<b>Total Example Cost</b>	<b>\$6,500</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What is NOT Covered</i>	
Limits or Exclusions	\$6,500
<b>The total Peg would pay is</b>	<b>\$6,500</b>

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

■ The Plan's Overall Deductible	\$3,000
■ Primary Care Visit Copay [ <i>Deductible Not Met</i> ]	\$0
■ Tier 2 Rx [ <i>Discounts are Passed to Member</i> ]	\$0
■ Lab Copay [ <i>Deductible Not Met</i> ]	\$0
■ Durable Medical Equipment [ <i>Not Covered</i> ]	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*)

<b>Total Example Cost</b>	<b>\$1,500</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What is NOT Covered</i>	
Limits or Exclusions	\$1,500
<b>The total Joe would pay is</b>	<b>\$1,500</b>

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

■ The Plan's Overall Deductible	\$3,000
■ Specialist Copay [ <i>Deductible Not Met</i> ]	\$0
■ ER Facility Services [ <i>Not Covered</i> ]	0%
■ Durable Medical Equipment [ <i>Not Covered</i> ]	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*)

<b>Total Example Cost</b>	<b>\$3,000</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What is NOT Covered</i>	
Limits or Exclusions	\$3,000
<b>The total Mia would pay is</b>	<b>\$3,000</b>

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