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 Deductible?	**$3,000/Individual $6,000/Family**	Generally, you must pay all of the costs from Providers up to the Deductible amount before this Plan begins to pay. If you have other family members on the Plan, the overall family Deductible must be met before the Plan begins to pay.
Are there services covered before you meet your Deductible?	**Yes**	This Plan covers Preventive Services even if you haven't yet met the Deductible amount, as long as Preventive Services are obtained from an in-network provider. Out of Network preventive services will be paid at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, Plan will pay UCR (Usual, Customary and Reasonable).
Are there other Deductibles for specific services?	**No**	Not Applicable
What is the Out-of-Pocket Limit for this Plan?	**$6,500/Individual $13,000/Family**	The Out-of-Pocket Limit is the most you could pay in a year for covered services. If you have other family members on this Plan, the overall family Out-of-Pocket Limit must be met.
What is not included inthe Out-of-Pocket Limit?	**Copayments on certain services, Premiums, Balance Billing charges, and services this Plan doesn't cover.**	Even though you pay these expenses, they don't count towards the Out-of-Pocket Limit
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 a provider Network. You will pay less if you use a Provider in the plan 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).
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 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	$35 Copay/Visit **AFTER** deductible is met.	$35 Copay/Visit, Up to Plan Limit **AFTER** deductible is met.	Copay with Network Provider applies after deductible is met. Out-of-network visits will not apply to deductible.
	Specialist Visit	$60 Copay/Visit **AFTER** deductible is met.	$60 Copay/Visit, Up to Plan Limit **AFTER** deductible is met.	Copay with Network Provider applies after deductible is met. Out-of-network visits will not apply to deductible.
	Preventive Care/Screening/ Immunization	No Charge*	No Charge, Up to Plan Limit*	*In-network Preventive Care is covered 100%. **Out-of-Network capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR.
If you have a test	Diagnostic Test (X-Ray)	Not Covered	Not Covered	
	Lab/Bloodwork	$10 Copay/Lab **AFTER** deductible is met.	$10 Copay/Lab, Up to Plan Limit **AFTER** deductible is met.	Copay with Network Provider applies after deductible is met. Out-of-network visits 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 Prescription Drug discounts is available at rx.planstin.com	Tier 1 - Generic	Check Discount Card	Not Covered	Check rx.planstin.com for More Information
	Tier 2 - Preferred Brand	Check Discount Card	Not Covered	Check rx.planstin.com for More Information
	Tier 3 - Non-Preferred Brand	Check Discount Card	Not Covered	Check rx.planstin.com for More Information
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 Transportation	Not Covered	Not Covered	
	Urgent Care	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	Outpatient Services	Not Covered	Not Covered	
	Inpatient Services	Not Covered	Not Covered	
If you are pregnant	Office Visit	$60 Copay/Visit **AFTER** deductible is met.	$60 Copay/Visit, Up to Plan Limit **AFTER** deductible is met.	Applies to specialist visits. Copay with Network Provider applies after deductible is met. Out-of-Network 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	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*	No Charge, Up to Plan Limit**	*In-network Preventive Care is covered 100%. **Out-of-Network capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR.
	Children's Glasses	Not Covered	Not Covered	
	Children's Fluoride Varnish	No Charge*	No Charge, Up to Plan Limit**	*In-network Preventive Care is covered 100%. **Out-of-Network capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR.

[* 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
- Diagnostic X-rays or Imaging
- Durable Medical Equipment
- Emergency Room Services
- Essure
- Genetic Testing / Genomic Sequencing
- Home Health Care / Hospice
- Hospital Admission or Facility
- Infertility Treatment
- Inpatient or Outpatient Surgery
- Labor and Delivery
- Long Term Care
- Pathology Services
- Tubal Ligation
- Urgent Care Office Visits
- 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 coverage is capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay usual, customary, and reasonable (UCR) rates.
- Primary care visits, specialist visits, and labs would apply to the deductible.
- Primary care visits, specialist visits, and labs count toward 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. 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 Claim, 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.

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 ofcosts 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 *[Deductible Not Met]*	**$0**
Imaging Copay *[Not Covered]*	**$0**
Lab Copay *[Deductible Not Met]*	
Hospital (Facility) *[Not Covered]*	**0%**

This EXAMPLE event includes services like:

Specialist Office Visits (*Prenatal Care) x5*
Diagnostic Tests (U*ltrasounds) 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	$3,000
Copayments	$0
Coinsurance	$0
What is NOT Covered	
Limits or Exclusions	$6,500
The total Peg would pay is	**$6,500**

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 *[Deductible Not Met]*	**$0**
Tier 2 Rx *[Discounts are Passed to Member]*	**$0**
Lab Copay [*Deductible Not Met]*	**$0**
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	$3,000
Copayments	$0
Coinsurance	$0
What is NOT Covered	
Limits or Exclusions	$1,500
The total Joe would pay is	**$1,500**

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

The Plan's Overall Deductible	**$3,000**
Specialist Copay *[Deductible Not Met]*	**$0**
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 Tests*(X-Ray)*
Durable Medical Equipment (Crutches*)*

Total Example Cost	**$3,000**

In this example, Mia would pay:

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

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