



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 <a href="#">Deductible</a> ?                                | \$0  | See the Common Medical Events chart below for your costs for services this <a href="#">Plan</a> covers.   |
| Are there services covered before you meet your <a href="#">Deductible</a> ?    | Not Applicable   | All covered services are based on a <a href="#">Copay</a> , percentage of cost or in-network rate, up to the visit and <a href="#">Plan</a> limits.   |
| Are there other <a href="#">Deductibles</a> for specific services?              | No   | This <a href="#">Plan</a> does not have a <a href="#">Deductible</a> .  |
| What is the <a href="#">Out-of-Pocket Limit</a> for this <a href="#">Plan</a> ? | Not Applicable   | This <a href="#">Plan</a> does not have an <a href="#">Out-of-Pocket Limit</a> on your expenses.  |
| What is not included in the <a href="#">Out-of-Pocket Limit</a> ?               | Not Applicable   | This <a href="#">Plan</a> does not have an <a href="#">Out-of-Pocket Limit</a> on your expenses.  |
| 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 the PHCS provider <a href="#">Network</a> . You will pay less if you use a <a href="#">Provider</a> in the plan <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 the <a href="#">Provider's</a> charge and what your <a href="#">Plan</a> pays ( <a href="#">Balance Billing</a> ). Be aware, your Network Provider might use an <a href="#">Out-of-Network Provider</a> for some services. |
| Are there Prescription Services?  | Yes  | <a href="#">Prescription</a> services available through PlanstinRx. The help desk can be reached at 435-893-7734. Start using all features of your prescription card by going to <a href="#">PlanstinRx</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> .  |

| Common Medical Event  | Services You May Need  | What You Will Pay                    |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--------------------------------------|--|---|
|   |  |                                      |  |   |
| If you visit a health care <b>Provider's</b> office or clinic   | <a href="#">Primary Care</a> Visit to Treat an Injury or Illness   | \$20 Copay/Visit<br>Unlimited Visits |  | For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> . Plan will pay a maximum of \$150 per visit.   |
|   | <a href="#">Specialist</a> Visit                                   | \$50 Copay/Visit<br>Unlimited Visits |  | For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> . Plan will pay a maximum of \$300 per visit.   |
|   | <a href="#">Preventive Care/Screening/Immunization</a>             | No Charge                            |  | <a href="#">Preventive Services</a> in-network with PHCS is covered at 100%. For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> .<br>If you receive a bill from your provider for Preventive Services, call Member Services at (888) 920-7526. |
| If you have a test  | <a href="#">Diagnostic Test</a> (X-Ray)<br>*Limit 5 per Plan Year  | \$50 Copay/X-Ray                     |  | For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> . Plan will pay a maximum of \$250 per X-Ray.   |
|   | Lab/Bloodwork<br>*Limit 15 per Plan Year                           | \$10 Copay/Lab                       |  | For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> . Plan will pay a maximum of \$100 per lab.   |
|   | Imaging (MRI, CT/PET Scans, Ultrasounds)<br>*Limit 2 per Plan Year | \$200 Copay/Test                     |  | For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> . Plan will pay a maximum of \$1000 per imaging test.   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">Prescription Drug discounts</a> is available at <a href="#">planstinrx.com</a> | Tier 1 - Generic   | \$10 Copay                           |  | Plan pays up to a maximum of \$150 per RX   |
|   | Tier 2 - Preferred Brand   | \$25 Copay                           |  | Plan pays up to a maximum of \$150 per RX   |
|   | Tier 3 - Non-preferred Brand                                       | \$50 Copay                           |  | Plan pays up to a maximum of \$150 per RX   |
|   | Tier 4 – <a href="#">Specialty</a>                                 | Not Covered                          |  | Not Covered   |
| If you have outpatient surgery  | Facility Fee / ASC   | Not Covered                          |  |   |
|   | Physician/Surgeon Fees   | Not Covered                          |  |   |
| If you need immediate medical attention   | <a href="#">Emergency Room Care</a>                                | Not Covered                          |  |   |
|   | <a href="#">Emergency Medical Transportation</a>                   | Not Covered                          |  |   |
|   | <a href="#">Urgent Care</a>  | \$50 Copay/Visit<br>Unlimited Visits |  | For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> . Plan will pay a maximum 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                       | Limitations, Exceptions, & Other Important Information |   |
|---|---|--|---|
|   |   | What You Will Pay                                      |   |
| If you have a hospital stay   | Facility Fee (i.e., Hospital Room)          | Not Covered  |   |
|   | Physician/Surgeon Fees                      | Not Covered  |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient Services                         | Not Covered  |   |
|   | Inpatient Services                          | Not Covered  |   |
| If you are pregnant   | Office Visit                                | \$50 Copay/Visit                                       | Copays apply to <a href="#">Specialist</a> visit copay limit. For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> . Plan will pay a maximum of \$300 per visit. |
|   | Childbirth / Delivery Professional Services | Not Covered  |   |
|   | Childbirth / Delivery Facility Services     | Not Covered  |   |
| If you need help recovering or have other special health needs            | <a href="#">Home Health Care</a>            | Not Covered  |   |
|   | <a href="#">Rehabilitation Services</a>     | Not Covered  |   |
|   | <a href="#">Habilitation Services</a>       | Not Covered  |   |
|   | <a href="#">Skilled Nursing Care</a>        | Not Covered  |   |
|   | <a href="#">Durable Medical Equipment</a>   | Not Covered  |   |
|   | <a href="#">Hospice Services</a>            | Not Covered  |   |
| If your child needs dental or eye care                                    | Children's Vision Acuity Screening          | No Charge  | <a href="#">Preventive Services</a> in-network with PHCS is covered at 100 For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> .                                |
|   | Children's Glasses                          | Not Covered  |   |
|   | Children's Fluoride Varnish                 | No Charge  | <a href="#">Preventive Services</a> in-network with PHCS is covered at 100%. For <a href="#">Out-of-Network</a> services, plan will pay 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay <a href="#">UCR (Usual, Customary and Reasonable)</a> .                              |

[\* 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       | • Labor & Delivery                 |
| • Adult Dental Care                   | • Emergency Room Services         | • Long Term Care                   |
| • Adult Vision Care                   | • Essure                          | • Major Diagnostic Tests           |
| • Anesthetic                          | • Genomic Sequencing Procedures   | • Pathology Services               |
| • Bariatric Surgery                   | • Hospital Admission or Facility  | • Physical or Occupational Therapy |
| • Cancer Treatment                    | • Infertility Treatment           | • Tubal Ligation                   |
| • Chiropractic Manipulative Treatment | • Inpatient or Outpatient Surgery | • 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 in-network with PHCS covered 100%.
- Preventive services/care out-of-network capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay [UCR](#).

**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.
- Using the rates negotiated with the provider for all services provided under a non-primary network contract or claim-specific agreement.

## 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            | \$0.00   |
| ■ Specialist Visit Copay                   | \$50.00  |
| ■ Imaging Copay                            | \$200.00 |
| ■ Lab Copay                                | \$10.00  |
| ■ 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>\$6,500.00</b> |
|---------------------------|-------------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                   |
|-----------------------------------|-------------------|
| Deductibles                       | \$0.00            |
| Copayments                        | \$750.00          |
| Coinsurance                       | \$0.00            |
| <i>What is NOT Covered</i>        |                   |
| Limits or Exclusions              | \$3,000.00        |
| <b>The total Peg would pay is</b> | <b>\$3,750.00</b> |

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

|  |         |
|--|---------|
| ■ The Plan's Overall Deductible                  | \$0.00  |
| ■ Primary Care Visit Copay                       | \$20.00 |
| ■ Tier 2 Rx Copay                                | \$25.00 |
| ■ Lab Copay                                      | \$10.00 |
| ■ 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>\$1,500.00</b> |
|---------------------------|-------------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |                 |
|-----------------------------------|-----------------|
| Deductibles                       | \$0.00          |
| Copayments                        | \$390.00        |
| Coinsurance                       | \$0.00          |
| <i>What is NOT Covered</i>        |                 |
| Limits or Exclusions              | \$350.00        |
| <b>The total Joe would pay is</b> | <b>\$740.00</b> |

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

|  |         |
|--|---------|
| ■ The Plan's Overall Deductible                  | \$0.00  |
| ■ Specialist Copay                               | \$50.00 |
| ■ 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 Tests (*X-Ray*)  
 Durable Medical Equipment (*Crutches*)

|                           |                   |
|---------------------------|-------------------|
| <b>Total Example Cost</b> | <b>\$3,000.00</b> |
|---------------------------|-------------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |                   |
|-----------------------------------|-------------------|
| Deductibles                       | \$0.00            |
| Copayments                        | \$250.00          |
| Coinsurance                       | \$0.00            |
| <i>What is NOT Covered</i>        |                   |
| Limits or Exclusions              | \$2,000.00        |
| <b>The total Mia would pay is</b> | <b>\$2,250.00</b> |

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