



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	This Plan does not have a Deductible .
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 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 PlanstinRx. The help desk can be reached at 435-893-7734. Start using all features of your prescription card by going to PlanstinRx .
Do you need a Referral to see a Specialist ?	No	You can see the Specialist you choose 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
		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	Not Covered	Not Covered	
	Specialist Visit	Not Covered	Not Covered	
	Preventive Care / Screening / Immunization	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.
If you have a test	Diagnostic Test (X-Ray)	Not Covered	Not Covered	
	Lab/Bloodwork	Not Covered	Not Covered	
	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 planstinrx.com	Tier 1 - Generic	Discounts May Be Available	Not Covered	Visit PlanstinSaveRx.com for Discount Card(s)
	Tier 2 - Preferred Brand	Discounts May Be Available	Not Covered	Visit PlanstinSaveRx.com for Discount Card(s)
	Tier 3 - Non-Preferred Brand	Discounts May Be Available	Not Covered	Visit PlanstinSaveRx.com for Discount Card(s)
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	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 Visits (Specialist)	Not Covered	Not Covered	
	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](#).)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Acupuncture• Adult Dental Care• Adult Vision Care• Anesthetic• Bariatric Surgery• Blood Transfusions or Plasma Treatments• Cancer Treatment• Cardiovascular Stress Tests | <ul style="list-style-type: none">• Chiropractic Manipulative Treatment• Durable Medical Equipment• Emergency Room Services• Essure• Genomic Sequencing Procedures• Hospital Admission or Facility• Infertility Treatment• Inpatient or Outpatient Surgery | <ul style="list-style-type: none">• Labor & Delivery• Major diagnostic tests• Mental health• Office Visits (primary care, specialist, urgent care)• 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.)

- 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.
- 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 [Not Covered]	\$0.00
■ Imaging Copay [Not Covered]	\$0.00
■ Lab Copay [Not Covered]	\$0.00
■ Hospital (Facility) [Not Covered]	\$0.00

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	\$0.00
Copayments	\$0.00
Coinsurance	\$0.00
What is NOT Covered	
Limits or Exclusions	\$6,500.00
The total Peg would pay is	\$6,500.00

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 [Not Covered]	\$0.00
■ Tier 2 Rx [Discounts are Passed to Member]	\$0.00
■ Lab Copay [Not Covered]	\$0.00
■ Durable Medical Equipment [Not Covered]	\$0.00

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	\$0.00
Copayments	\$0.00
Coinsurance	\$0.00
What is NOT Covered	
Limits or Exclusions	\$1,500.00
The total Joe would pay is	\$1,500.00

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

■ The Plan's Overall Deductible	\$0.00
■ Specialist Copay [Not Covered]	\$0.00
■ ER Facility Services [Not Covered]	\$0.00
■ Durable Medical Equipment [Not Covered]	\$0.00

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	\$3,000.00
---------------------------	-------------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0.00
Copayments	\$0.00
Coinsurance	\$0.00
What is NOT Covered	
Limits or Exclusions	\$3,000.00
The total Mia would pay is	\$3,000.00

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