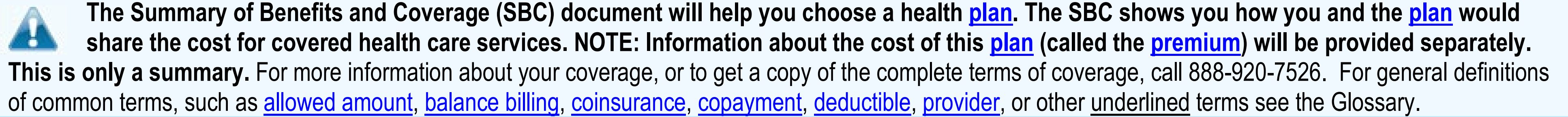

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 888-920-7526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Not applicable**	Plan does not have a deductible that needs to be met.
Are there services covered before you meet your deductible?	**Not applicable**	In-network savings applied with all network providers and applicable services.
Are there other deductibles for specific services?	**Not applicable**	
What is the out-of-pocket limit for this plan?	**Not applicable**	Plan does not have an out-of-pocket limit that needs to be met.
What is not included in the out-of-pocket limit?	**Not applicable**	Services not covered are not included in the out-of-pocket limit for the plan.
Will you pay less if you use a network provider?	Yes. Preventive services are only covered in network.	PPO network available through PHCS, specific services. To find a provider, call 800-922-4362 or visit www.multiplan.com.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
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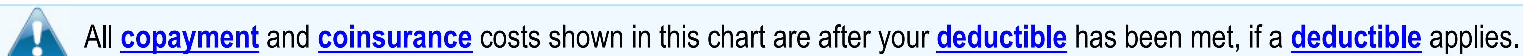

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	
	Specialist visit	Not covered	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray)	Not covered	Not covered	
	Lab/Blood work	Not covered	Not covered	
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	Not covered	Not covered	
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	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	
If you have a hospital stay	Facility fee (e.g., 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	Not covered	Not covered	
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility servs	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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 eye exam	No charge	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge	Not covered	

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.)

- Hospital Admission or Facility
- Bariatric Surgery
- Emergency Room Services
- Inpatient or Outpatient Surgery
- Acupuncture
- Long Term Care
- Adult Dental Care
- Adult Vision Care
- Infertility Treatment

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Preventive care, limited to in-network services

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be 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 1-800-318-2596.

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 888-7526 or member@planstin.com.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll 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 doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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 *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$6,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	NA
Copayments	NA
Coinsurance	NA
What isn't covered	
All Services Listed	$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** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$1,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	NA
Copayments	NA
Coinsurance	NA
What isn't covered	
All Services Listed	$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** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$3,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	NA
Copayments	NA
Coinsurance	NA
What isn't covered	
All Services Listed	$3,000
The total Mia would pay is	**$3,000**

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