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, call 888-920-7526.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,000 per individual / $6,000 family**	Once deductible is met, plan includes copays for specific services. Deductible is met with in-network costs for covered services.
Are there services covered before you meet your deductible?	**No**	In-network savings applied with all network providers and applicable services.
Are there other deductibles for specific services?	**No**	
What is the out-of-pocket limit for this plan?	**$6,500 per individual / $13,000 family**	Copays for covered services cannot exceed the out-of-pocket limit for the plan.
What is not included in the out-of-pocket limit?	**Services not covered in plan**	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. Specific coverages are only covered in network. Larger copays apply to out of network services.**	PPO network available through PHCS, specific services. To find a provider, call 800-922-4362 or visit www.multiplan.com.
Are there prescription services?	**Yes**	Discount prescription card where you can save 75% on select prescriptions. Start using your discount prescription card by going to rx.planstin.com
Do you need a referral to see a specialist?	**No**	You can see the specialist you choose without permission from this plan.

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 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	$50 copay/visit	Not covered	Copay applies after deductible is met.
	Specialist visit	$100 copay/visit	Not covered	Copay applies after deductible is met.
	Preventive care / screening / immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray)	$100 copay/test	Not covered	Copay applies after deductible is met.
	Lab/Blood work	$25 copay/test	Not covered	Copay applies after deductible is met.
	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.planstin.com	Tier 1 - Generic	Check discount card	Check discount card	Check rx.planstin.com for more information
	Tier 1 - Generic	Check discount card	Check discount card	Check rx.planstin.com for more information
	Tier 3 - Non-preferred brand	Check discount card	Check discount card	Check rx.planstin.com for more information
	Tier 4	Check discount card	Check discount card	Check rx.planstin.com for more information
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	

[* For more information about limitations and exceptions, see the plan or policy document at www.Planstin.com.]

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 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	$100 copay/visit	Not covered	Copay applies after deductible is met.
	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 eye exam	No charge	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge	Not covered	

[* For more information about limitations and exceptions, see the plan or policy document at www.Planstin.com.]

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
- Tubal Ligation
- Anesthetic
- Inpatient or Outpatient Surgery
- Acupuncture
- Long Term Care
- Vasectomy
- Cancer Removal
- Adult Dental Care
- Adult Vision Care
- Infertility Treatment
- Essure
- Durable Medical Equipment

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

- Chiropractic Care, limited by number of visits
- Doctor visits, limited by number of visits
- 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: 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 http://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 888-920-7526 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.

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 current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical differences where applicable, plus a margin factor.
- 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.

[* For more information about limitations and exceptions, see the plan or policy document at www.Planstin.com.]

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

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	$3,000
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6000
The total Peg would pay is	**$6000**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$**
- **Specialist [cost sharing]** **$**
- **Hospital (facility) [cost sharing]** **%**
- **Other [cost sharing]** **%**

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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$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	$3,000
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,500
The total Mia would pay is	**$2,800**

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