This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.phs.org. or by calling 1-800-923-6980.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$500** person / **$1000** family Out-of-network: **$1000** person / **$2000** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$3000** person / **$6000** family Out-of-network: **$6000** person / **$12000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See **www.phs.org or call 1-800-923-6980** for a list of **participating providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist ?	No. You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit - not subject to deductible. All other services subject to deductible and 20% coinsurance.	40% coinsurance	----------None----------
	Specialist visit	$30 copay/visit - not subject to deductible. All other services subject to deductible and 20% coinsurance.	40% coinsurance	----------None----------
	Other practitioner office visit	20% coinsurance for acupuncture and chiropractor	40% coinsurance for acupuncture and chiropractor	Coverage is limited up to 20 visits/calendar year for acupuncture and 20 visits/calendar year for chiropractor if medically necessary.
	Preventive care/screening/immunization	No charge	40% coinsurance	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for x-ray / No charge for blood work	40% coinsurance	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior authorization may be required.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.phs.org/tools-resources/member/Pages/forms-and-documents.aspx.	Generic Drugs	$10 copay (retail) / $20 copay (mail order)	$10 copay (retail) / $20 copay (mail order)	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription)
	Preferred brand drugs	$35 copay (retail) / $87.50 copay (mail order)	$35 copay (retail) / $87.50 copay (mail order)	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription)
	Non-preferred drugs	$55 copay (retail) / $165 copay (mail order)	$55 copay (retail) / $165 copay (mail order)	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription)
	Specialty drugs	20% up to a maximum of $400 per prescription (retail) / Not available (mail order)	20% up to a maximum of $400 per prescription (retail) / Not available (mail order)	----------None----------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior authorization may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior authorization may be required.
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	----------None----------
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------None----------
	Urgent care	$30 copay/visit - not subject to deductible. All other services subject to deductible and 20% coinsurance.	$30 copay/visit - not subject to deductible. All other services subject to deductible and 20% coinsurance.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization may be required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Prior authorization may be required.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental Behavioral Health Outpatient Services	$20 copay/visit - not subject to deductible.	40% coinsurance	----------None----------
	Mental Behavioral Health Inpatient Services	20% coinsurance	40% coinsurance	Prior authorization may be required.
	Substance use disorder outpatient services	$20 copay/visit - not subject to deductible.	40% coinsurance	----------None----------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Prior authorization may be required.
If you are pregnant	Prenatal and postnatal care	$20 copay/visit - not subject to deductible. All other services subject to deductible and 20% coinsurance.	40% coinsurance	----------None----------
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Prior authorization may be required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Prior authorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage is limited up to a combined total of 24 visits combined/calendar year; combined in- and out-if-network. Prior authorization may be required.
	Habilitation services	20% coinsurance	40% coinsurance	Prior authorization may be required.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited up to 60 days per calendar year. Prior authorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior authorization may be required. Hearing aids are covered for school aged children under 21 if still attending high school every 36 months/hearing impaired ear.
	Hospice service	20% coinsurance	40% coinsurance	Prior authorization may be required.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	20% coinsurance	40% coinsurance	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction.
	Glasses	20% coinsurance	40% coinsurance	Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery or the correction of Keratoconus. Prior authorization may be required.
	Dental check up	Not covered	Not covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-up (Child)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids for school aged children
- Infertility Treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-923-6980. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-800-923-6980.

The Managed Health Care Bureau of the Office of the Superintendent of Insurance is also available to assist you with Grievances, questions or Complaints; call 1-855-427-5674.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Language Access Services

Para obtener asistencia en Español, llame al 1-800-923-6980.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-923-6980.

如果需要中文的帮助，请拨打这个号码 1-800-923-6980.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-923-6980.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $5620**
- **Patient pays $1920**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$500
Co-pays	$20
Coinsurance	$1250
Limits or exclusions	$150
Total	$1920

Managing type 2 diabetes
(routine maintenance of (a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $4030**
- **Patient pays $1370**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$500
Co-pays	$580
Coinsurance	$210
Limits or exclusions	$80
Total	$1370

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.