PLAN UPDATES

PREVENTIVE ADVANCED

Planstin is thrilled to announce that we are rolling out some exciting enhancements for the Preventive Advanced Base Health Plan!

Beginning April 1, 2023, members are no longer restricted to the PHCS provider network for preventive care. Planstin will cover out-of-network preventive services using reference-based pricing (RBP). Members will also now have access to 5 additional labs per year, taking the annual allotment from 10 to 15 labs per plan year. Best of all, primary care, specialist, and urgent care visits are now unlimited!

SERVICE COPAYS

Service	In-network copay	Out-of-network copay	Max Per Visit/Service	Visit Limits per year
Teladoc® consultation	$0	$0	Unlimited	Unlimited
Preventive care, screening, immunizations	$0	Covered up to plan limits*	Unlimited in Network	Unlimited in Network
Primary care visit	$20	$50	$150	Unlimited
Specialist visit	$50	$100	$300	Unlimited
Diagnostic x-ray	$50	$100	$250	5
Lab/bloodwork	$10	$25	$100	15
Imaging (CT/PET scans, ultrasounds, MRIs)	$200	$400	$1,000	2
Urgent care visit	$50	$100	$300	Unlimited
Children's vision acuity screening	$0	Covered up to plan limits*	Unlimited in Network	Unlimited in Network
Children's fluoride varnish	$0	Covered up to plan limits*	Unlimited in Network	Unlimited in Network

*Plan will pay 150% of Medicare reimbursement rates. In the absense of a Medicare rate, plan will pay UCR (usual, customary, and reasonable).

PREVENTIVE SERVICES
Included

TELEMEDICINE
$0 Copay

PRESCRIPTION BENEFITS
Included

COPAY OPTIONS
Included

PHCS + RBP

TELADOC® Telehealth 24/7/365

Optum Rx® Prescription copays

To learn more about the Preventive Advanced Plan, visit Planstin.com or call our Member Services team at 888-920-7526.

COPAGO PREVENTIVO

ESQUEMA

Su plan de salud Planstin Copago Preventivo incluye cuidados preventivos, copagos por visitas al médico, cobertura de recetas, y una afiliación a Teladoc®. No hay límite de servicios del plan para enfermedades preexistentes. Este esquema es un descripción general de su plan. Para más información, consulte el resumen de beneficios y cobertura (SBC) del plan.

COPAGOS Y LÍMITES

Servicio	En la red	Fuera de la red	Pago máximo	Límite del año plan
Análisis de laboratorio	$10	$25	$100/lab	15 labs
Visita de atención primaria	$20	$50	$150/visita	Ilimitado
Visita al especialista	$50	$100	$300/visita	Ilimitado
Visita de emergencias	$50	$100	$300/visita	Ilimitado
Rayos X diagnóstico	$50	$100	$250/Rayos X	5 rayos X
TAC, IRM, ecografía	$200	$400	$1000/visita	2 exámenes

CUIDADO PREVENTIVO

Su plan ofrece una cobertura del 100% por servicios preventivos según lo establecido por la Ley de Cuidado de Salud Asequible. Si recibe una factura por un servicio preventivo cubierto por su plan, contacte inmediatamente a Servicios a los Miembros de Planstin llamando al 888-920-PLAN.

1506 S Silicon Way Suite 2B, St. George, UT 84770 | 888-920-7526 | Planstin.com

TELEMEDICINA

Su plan incluye la afiliación al principal proveedor de telemedicina en los Estados Unidos. Teladoc® provee acceso ilimitado y constante a un médico, sin copagos para visitas médicas generales.

Servicio de Teladoc®	Copago
Visita médica general	$0
Consulta dermatológica	$85
Visita a un terapeuta licenciado	$90
Visita al psiquiatra (Continua)	$100
Visita al psiquiatra (Evaluación)	$220

PRESCRIPCIONES

Servicio de Teladoc®	Copago	Pago máximo por mes
Nivel 1: Bajo costo	$10	$150/RX
Nivel 2: Genérico	$25	$150/RX
Nivel 3: Marca preferida	$50	$150/RX

Nota: Para obtener más información sobre sus beneficios de medicamentos redetados, visite planstinrx.com.

LA RED

Su plan le brinda acceso a la red nacional de médicos PPO de PHCS/Multiplan. Puede buscar un proveedor de la red en Planstin.com/PHCS o llamar al 800-922-4362. Para los servicios del plan fuera de la red, su plan emplea una estrategia de precios basados en referencias (RBP). Los importes de pago de la tarificación basada en referencias son el 150% de las tarifas de reembolso de Medicare. A falta de una tarifa de Medicare, su plan pagará la tarifa habitual, acostumbrada y razonable (UCR) del sector para su zona geográfica.

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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**	All covered services are based on a Copay, percentage of cost or in-network rate, up to the visit and Plan limits.
Are there other Deductibles 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 inthe 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's 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 OptumRx. The pharmacy help desk can be reached at 877-633-4461. Start using all features of your prescription card by going to the OptumRx Portal.
Do you need a Referral to see a Specialist?	**No**	You can see the Specialist you choose without a Referral.

[* 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 visit a health care Provider's office or clinic	Primary Care Visit to Treat an Injury or Illness	$20 Copay/Visit	$50 Copay/Visit	Plan pays for a max of 5 visits per plan year ($150 max per visit). Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR, up to $150.
	Specialist Visit	$50 Copay/Visit	$100 Copay/Visit	Plan pays for a max of 5 visits per plan year ($300 max per visit). Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR, up to $300.
	Preventive Care/Screening/ Immunization	No Charge*	No Charge, Up to Plan Limit**	*In-network Preventive Care is covered 100%. **Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR.
If you have a test	Diagnostic Test (X-Ray)	$50 Copay/X-Ray	$100 Copay/X-Ray	Plan pays for a max of 5 diagnostic x-rays per plan year ($250 max per x-ray). Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR, up to $250.
	Lab/Bloodwork	$10 Copay/Lab	$25 Copay/Lab	Plan pays for a max of 10 labs per plan year ($100 max per lab). Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR, up to $100.
	Imaging (MRI, CT/PET Scans, Ultrasounds)	$200 Copay/Test	$400 Copay/Test	Plan pays for a max of 2 imaging services per plan year ($1,000 max per test). Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR, up to $1,000.
If you need drugs to treat your illness or condition More information about Prescription Drug discounts is available at rx.planstin.com	Tier 1 - Generic	$10 Copay	Not Covered	Plan pays up to a maximum of $150 per RX
	Tier 2 - Preferred Brand	$25 Copay	Not Covered	Plan pays up to a maximum of $150 per RX
	Tier 3 - Non-preferred Brand	$50 Copay	Not Covered	Plan pays up to a maximum of $150 per RX
	Tier 4 – Specialty	Excluded	Not Covered	May be excluded from coverage or subject to prior authorization.
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 Transportation	Not Covered	Not Covered	

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

	Urgent Care	$50 Copay/Visit	$100 Copay/Visit	Plan pay for a max of 5 Urgent Care visits per plan year ($300 max per visit). Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR, up to $300.
If you have a hospital stay	Facility Fee (i.e., Hospital Room)	Not Covered	Not Covered	
	Physician/Surgeon Fees	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 will pay the least)	Out-of-Network Provider (You will pay the most)	
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 Visit	$50 Copay/Visit	$100 Copay/Visit	Copays apply to Specialist visit copay limit. Plan pays for a max of 5 visits per plan year ($300 max per visit). Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR, up to $300.
	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**	*In-network Preventive Care is covered 100%. **Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR.
	Children's Glasses	Not Covered	Not Covered	
	Children's Fluoride Varnish	No Charge*	Not Covered**	*In-network Preventive Care is covered 100%. **Out-of-network coverage capped at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan will pay UCR.

[* 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.)

- Acupuncture
- Adult Dental Care
- Adult Vision Care
- Anesthetic
- Bariatric Surgery
- Cancer Treatment
- Chiropractic Manipulative Treatment
- Durable Medical Equipment
- Emergency Room Services
- Essure
- Genomic Sequencing Procedures
- Hospital Admission or Facility
- Infertility Treatment
- Inpatient or Outpatient Surgery
- Labor & Delivery
- Long Term Care
- Major Diagnostic Tests
- 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.)

- 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. 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, 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.

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

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 ofcosts 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 Visit Copay** **$50**
- **Imaging Copay** **$200**
- **Lab Copay** **$10**
- **Hospital (facility)** ***[Not Covered]*** **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)*

Total Example Cost	**$6,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$750
Coinsurance	$0
What is NOT Covered	
Limits or Exclusions	$3,000
The total Peg would pay is	**$3,750**

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

- **The plan's overall deductible** **$0**
- **Primary Care Visit Copay** **$20**
- **Tier 2 Rx Copay** **$25**
- **Lab Copay** **$10**
- **Durable Med Equipment** ***[Not Covered]*** **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)*

Total Example Cost	**$1,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$390
Coinsurance	$0
What is NOT Covered	
Limits or Exclusions	$350
The total Joe would pay is	**$740**

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

- **The plan's overall deductible** **$0**
- **Specialist Copay** **$50**
- **ER Facility Services** ***[Not Covered]*** **0%**
- **Durable Med Equipment** ***[Not Covered]*** **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*)*

Total Example Cost	**$3,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$250
Coinsurance	$0
What is NOT Covered	
Limits or Exclusions	$2,000
The total Mia would pay is	**$2,250**

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