

PREVENTIVE BASIC

Make preventive care routine.



PREVENTIVE CARE INCLUDED

PREVENTIVE PLAN SUMMARY

Your Preventive Basic health plan includes telemedicine, preventive services, and access to PlanstinSaveRx prescription discounts. There is no deductible and no limit on plan services for pre-existing conditions. This is an outline of your coverage. Please see your plan's summary of benefits and coverage (SBC) for more details.

Your plan provides coverage for preventive services as outlined by the Affordable Care Act. When performed in-network with PHCS, there are no copays, deductibles, or other out of pocket costs required for preventive care. For examples of the preventive services covered by your plan, visit [healthcare.gov/coverage/preventive-care-benefits](https://www.healthcare.gov/coverage/preventive-care-benefits).



NEED HELP?

If you receive a bill for a preventive service covered by your plan, contact a Benefit Advocate immediately: **888-920-7526**.



PRESCRIPTION DISCOUNT PROGRAM

Home Delivery

Skip the line at the pharmacy, save more with 90-day supplies, and never forget a refill.

Discounts

Save up to 80% at over 60,000 participating partner pharmacy locations nationwide.

User-Friendly

Quickly find the medications you need at the best price with an easy, online search tool.

PAP

Complete a short online form to see if you qualify for the prescription assistance program.

Visit [planstinsaverx.com](https://www.planstinsaverx.com) to learn more and get started.



NATIONWIDE NETWORK

NETWORK

This health plan provides access to the PHCS/Multiplan national PPO network of providers. You can search for a provider at [planstin.com/PHCS](https://www.planstin.com/PHCS) or call 800-922-4326.




TELEMEDICINE

A Teladoc® membership is included with this health plan. Membership provides unlimited access to a physician 24/7/365, with no copay for general medical visits.



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 a Benefit Advocate at (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. You can view the Glossary at www.healthcare.gov/sbc-glossary.com or call 888-920-7526 to request a copy.

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 , but a copayment may apply. This plan covers certain preventive services without cost sharing . See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
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 MultiPlan website or call 866-981-7427 for a list of network providers .	This plan uses a 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 (such as lab work). Check with your provider before you get services. This plan uses MultiPlan's PHCS Specific Services Network.
Do you need a referral to see a specialist ?	No	There is no coverage for specialist visits included in 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	Not Covered	Not Covered	No Coverage for primary care services.
	Specialist visit	Not Covered	Not Covered	No Coverage for specialist visits.
	Preventive care/screening/immunization	No Charge*	Not Covered	*Preventive care must be received in-network to be covered. Out-of-network preventive care is not covered under this health plan. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive , then check what your plan will pay for. In-office procedures may not be covered. If you receive a bill for preventive services received in-network, call a Benefit Advocate at (888) 920-7526.
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	No Coverage for diagnostic tests , including diagnostic labs.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	No Coverage for imaging.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at PlanstinRx.com	Generic drugs	Not Covered*	Not Covered	Discounts may be available. Check for discount cards at PlanstinRx.com or PlanstinSaveRx.com for quick access.
	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	No coverage for Surgical care.
	Physician/surgeon fees	Not Covered	Not Covered	No coverage for Surgical care.
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	No Coverage for Emergency room care .
	Emergency medical transportation	Not Covered	Not Covered	No Coverage for Emergency medical transportation .
	Urgent care	Not Covered	Not Covered	No Coverage for Urgent care services.

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://helpdesk.planstin.com/benefit-information>

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	No Coverage for Inpatient care.
	Physician/surgeon fees	Not Covered	Not Covered	No Coverage for Inpatient care.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	No Coverage for Outpatient care.
	Inpatient services	Not Covered	Not Covered	No Coverage for Inpatient care.
If you are pregnant	Office visits	Not Covered	Not Covered	No Coverage for Office visits.
	Childbirth/delivery professional services	Not Covered	Not Covered	No Coverage for Childbirth and delivery services.
	Childbirth/delivery facility services	Not Covered	Not Covered	No Coverage for Childbirth and delivery services at any facility.
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	No Coverage for private-duty nursing, home health aides, respite, custodial, supportive, or rest care.
	Rehabilitation services	Not Covered	Not Covered	No Coverage for Rehabilitation services .
	Habilitation services	Not Covered	Not Covered	No Coverage for Habilitation services .
	Skilled nursing care	Not Covered	Not Covered	No Coverage for Skilled nursing care .
	Durable medical equipment	Not Covered	Not Covered	No Coverage for Medical equipment .
	Hospice services	Not Covered	Not Covered	No Coverage for Hospice services .
If your child needs dental or eye care	Children's eye exam	No Charge *	No Charge *	No Coverage for vision care, except as otherwise covered in Section VI of the Summary Plan Description.
	Children's glasses	Not Covered	Not Covered	No Coverage for contacts, lenses, and frames.
	Children's dental check-up	No Charge *	No charge *	No Coverage for dental care, except as otherwise covered in Section VI of the Summary Plan Description.

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://helpdesk.planstin.com/benefit-information>

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
- Allergy Services
- Asthma Treatment, therapeutic
- Bariatric Surgery
- Cancer-related therapies
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Psychiatric Services
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

Preventive care or services are required to be obtained In-network to qualify for coverage. Out-of-network 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. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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: Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al (888) 920-7526.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 920-7526.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (888) 920-7526.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (888) 920-7526.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://helpdesk.planstin.com/benefit-information>

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](#) visit [coinsurance](#) none
- Hospital (facility) [coinsurance](#) none
- Other [coinsurance](#) none

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$12,800

The total Peg would pay is	\$12,800
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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](#) visit [coinsurance](#) none
- Hospital (facility) [coinsurance](#) none
- Other [coinsurance](#) none

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$7,400

The total Joe would pay is	\$7,400
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) visit [coinsurance](#) none
- Hospital (facility) [coinsurance](#) none
- Other [coinsurance](#) none

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	\$2,500
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$2,500

The total Mia would pay is	\$2,500
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.