

# PREVENTIVE COPAY

Accessible care at an affordable price.



**PREVENTIVE CARE INCLUDED**

## PREVENTIVE PLAN SUMMARY

Your Preventive Copay health plan includes telemedicine, copays for doctor visits, a PlanstinRx membership, and coverage for preventive care as outlined by the Affordable Care Act. 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).

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



**AFFORDABLE COPAYS**

Service	Copay	Max Payout	Plan Year Limit
Lab Work	\$10	\$100/Lab	15 Labs
Primary Care Visit	\$20	\$150/Visit	No Limit
Specialist Care Visit	\$50	\$300/Visit	No Limit
Urgent Care Visit	\$50	\$300/Visit	No Limit
Diagnostic X-ray	\$50	\$250/X-ray	5 X-rays
CAT-scan, MRI, Ultrasound	\$200	\$1,000/Test	2 Tests

There is no limit on plan services for pre-existing conditions. Please see your plan's summary of benefits and coverage (SBC) for more details.



**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://planstin.com/PHCS) or call 800-922-4326.



**PLANSTINRX MEMBERSHIP**

Prescription coverage, home delivery, and significant discounts on brand name and Tier 4 specialty medications. Visit [planstinrx.com](https://planstinrx.com) to get started.

Prescription Tier	Retail (30)	Mail (90)	Max Payout/Month
Tier 1: Generics	\$10	\$20	\$150/Rx
Tier 2: Preferred Brand	\$25	\$50	\$150/Rx
Tier 3: Non-Preferred Brand	\$50	\$100	\$150/Rx




**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](http://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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not Applicable	This <a href="#">plan</a> does not have a <a href="#">deductible</a> , but a <a href="#">copayment</a> may apply. This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See the <a href="#">MultiPlan website</a> or call 866-981-7427 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. <b>This <a href="#">plan</a> uses MultiPlan's PHCS Specific Services Network.</b>
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. [Copayment](#) for office visits apply to visits only. In-office procedures may not be covered. Out-of-Network care is covered at 150% of Medicare reimbursement rates. In the absence of a Medicare rate the [plan](#) will pay [UCR](#).

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	\$20 <a href="#">copay</a> /visit	\$20 <a href="#">copay</a> /visit	<a href="#">Plan</a> will pay up to \$150/visit.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> /visit	<a href="#">Plan</a> will pay up to \$300/visit.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> , then check what your <a href="#">plan</a> will pay for. <b>If you receive a bill for preventive services, call a Benefit Advocate at (888) 920-7526.</b>
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copay</a> /x-ray \$10 <a href="#">copay</a> /lab test	\$50 <a href="#">copay</a> /x-ray \$10 <a href="#">copay</a> /lab test	<a href="#">Copayments</a> apply to lab work on a per-test basis, not per draw or per sample. X-Ray limit 5/plan year and \$250/x-ray limit. Lab test limit 15/plan year and \$100/lab test limit.
	Imaging (CT/PET scans, MRIs)	\$200 <a href="#">copay</a> /test	\$200 <a href="#">copay</a> /test	Covered services: CAT/CT, MRI, Ultrasound. Imaging limit 2/plan year and \$1,000/test limit.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.planstinrx.com">www.planstinrx.com</a>	Generic drugs (low-cost)	\$10 <a href="#">copay</a> /prescription (retail), \$20 <a href="#">copay</a> /prescription (mail order)	Not Covered	Plan pays up to a maximum of \$150/prescription per month. No Coverage for <a href="#">Specialty Drugs</a> . Discounts are available for many medications through <a href="http://www.PlanstinSaveRx.com">www.PlanstinSaveRx.com</a> . Pharmacy Services: 435-893-7734
	Preferred brand drugs (non-formulary generic)	\$25 <a href="#">copay</a> /prescription (retail), \$50 <a href="#">copay</a> /prescription (mail order)	Not Covered	
	Non-preferred brand drugs (brand)	\$50 <a href="#">copay</a> /prescription (retail), \$100 <a href="#">copay</a> /prescription (mail order)	Not Covered	
	<a href="#">Specialty drugs</a>	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.

\* 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 need immediate medical attention	<a href="#">Emergency room care</a>	Not Covered	Not Covered	No Coverage for <a href="#">Emergency room care</a> .
	<a href="#">Emergency medical transportation</a>	Not Covered	Not Covered	No Coverage for <a href="#">Emergency medical transportation</a> .
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> /visit	<a href="#">Plan</a> will pay up to \$300/visit.
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	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> /visit	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> may apply.
	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	<a href="#">Home health care</a>	Not Covered	Not Covered	No Coverage for private-duty nursing, home health aides, respite, custodial, supportive, or rest care.
	<a href="#">Rehabilitation services</a>	Not Covered	Not Covered	No Coverage for <a href="#">Rehabilitation services</a> .
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	No Coverage for <a href="#">Habilitation services</a> .
	<a href="#">Skilled nursing care</a>	Not Covered	Not Covered	No Coverage for <a href="#">Skilled nursing care</a> .
	<a href="#">Durable medical equipment</a>	Not Covered	Not Covered	No Coverage for <a href="#">Medical equipment</a> .
	<a href="#">Hospice services</a>	Not Covered	Not Covered	No Coverage for <a href="#">Hospice services</a> .
If your child needs dental or eye care	Children's eye exam	No Charge *	No Charge *	No Coverage for vision care, except as 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 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.)

Both in- and out-of-network [cost-sharing](#) amounts will be applied to the [deductible](#) and [out-of-pocket max](#), limited to RBP/UCR rates only. Any [balance billing](#) charges or charges for services not covered under this health [plan](#) will not be applied to the [deductible](#) or [out-of-pocket maximums](#).

**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](http://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](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 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](http://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, kwiiijigo 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 [copayment](#) \$50
- 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)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$12,500

<b>The total Peg would pay is</b>	<b>\$12,800</b>
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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 [copayment](#) \$50
- 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)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$6,200

<b>The total Joe would pay is</b>	<b>\$7,400</b>
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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 [copayment](#) \$50
- 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)

<b>Total Example Cost</b>	<b>\$2,500</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$2,300

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