Planstin – Preventive Advanced

Coverage Period: January 1, 2018 - December 31, 2018

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual Family | Plan Type: PPO

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 by calling 888-920-7526

Important Questions	Answers	Why this Matters:
What is the overall deductible?	No Deductible	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.	
Is there an out-of-pocket limit on my expenses?	In Network Out of Pocket maximum is $6,850 per individual and $13,700 per family. Out of Network Out of Pocket does not have a maximum.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for your health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Prior Authorization Penalties, and health care this plan does not 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 titled Common Medical Event describes any limits on what the insurer will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of Network Providers call (800) 922-4362 or visit www.multiplan.com	By utilizing in network providers, you have access to discounted rates for services.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan. You must see a participating specialist
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the box titled Services Your Plan Does Not Cover. See your policy or plan document for information about excluded services.

Questions: Call 888-920-7526 or visit us at www.planstin.com. If you aren't clear about any of the underlined terms in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive this 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 a		Limitations & Exceptions
		Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	$20 copay/visit	Max 3 Visits per calendar year.
	Specialist visit	$50 copay/visit	$50 copay/visit	Max 3 Visits per calendar year.
	Other practitioner office visit	Not covered	Not covered	
	Preventive care/screening/immunization	No charge	No charge	
If you have a diagnostic test or imaging service	Diagnostic test (x-ray, blood work)	$50 copay/visit	$50 copay/visit	In office, max 5 services per calendar year.
	Imaging (CT/PET scans, MRIs)	$200 copay/visit	$200 copay/visit	Max 1 Cat-Scan, 1 MRI per calendar year.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Tier 1 – Low Cost Generics	$1 Copay	$1 Copay	.
	Tier 2 - Generics	10% Coinsurance	10% Coinsurance	
	Tier 3 – Preferred Brand	20% Coinsurance	20% Coinsurance	
	Tier 4 – Non-Preferred Brand	40% Coinsurance	40% Coinsurance	
	Tier 5 – Generic and Preferred Specialty	10% Coinsurance	10% Coinsurance	Plan Pays 90% up to a maximum of $150 per Rx
	Tier 6 – Non-Preferred Specialty	20% Coinsurance	20% Coinsurance	Plan Pays 80% up to a maximum of $250 per Rx
If you have an 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 services	Not covered	Not covered	
	Emergency medical transportation	Not covered	Not covered	
	Urgent care	$50 Copay/visit	$50 Copay/visit	Max 3 visits per calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Out-Of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not covered	
	Physician/surgeon fee	Not covered	Not covered	
If you have mental health or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	
	Mental/Behavioral health inpatient services	Not covered	Not covered	
	Substance use disorder outpatient services	Not covered	Not covered	
	Substance use disorder inpatient services	Not covered	Not covered	
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered	
	Delivery and all inpatient 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 service	Not covered	Not covered	
If you need an eye exam	Eye exam	No charge	No Charge	Exam Only Covered and member may choose any physician

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	Out-Of-Network Provider	
	Dental Check-up	No charge	No charge	Coverage limited to children as part of required preventive care services. Exam only covered and member may choose any provider.

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.)

- Acupuncture
- Bariatric surgery
- Dental Care
- Chiropractic Care
- Hearing Aids
- Long Term Care
- Non-Emergency Care When Traveling Outside the US
- Private-duty Nursing
- Routine Foot Care
- Weight Loss Programs
- Infertility Treatment
- Routine Eye Care Adult

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 855-257-0145. 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 the plan at 855-257-0145. 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.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This plan or policy does provide minimum essential coverage.

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.

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

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 pre-existing 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.