



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 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 <a href="#">Deductible</a> ?	<b>MEDICAL</b> \$5,000 / Ind \$9,000 / Family	<b>PRESCRIPTION</b> \$1,000 / Ind \$2,000 / Family	Generally, you must pay all of the costs from <a href="#">Providers</a> up to the <a href="#">Deductible</a> amount before this <a href="#">Plan</a> begins to pay. If you have other family members on the <a href="#">Plan</a> , each family member must meet their own individual <a href="#">Deductible</a> until the total amount of <a href="#">Deductible</a> expenses paid by all family members meets the overall family deductible. The medical and prescription deductibles accumulate separately.
Are there services covered before you meet your <a href="#">Deductible</a> ?	Yes. <a href="#">Preventive Services</a> are covered before you meet your <a href="#">Deductible</a>		This <a href="#">Plan</a> covers <a href="#">Preventive Services</a> even if you haven't yet met the <a href="#">Deductible</a> amount. See a list of covered Preventive Services at located at the ACA website by visiting <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">Deductibles</a> for specific services?	No		Not Applicable.
What is the <a href="#">Out-of-Pocket Limit</a> for this <a href="#">Plan</a> ?	<b>MEDICAL</b> \$7,900 / Ind \$16,000 / Family	<b>PRESCRIPTION</b> \$1,200 / Ind \$2,100 / Family	The <a href="#">Out-of-pocket Limit</a> is the most you could pay in a plan year for covered services. If you have family members on this <a href="#">Plan</a> , they have to meet their own <a href="#">Out-of-Pocket Limits</a> until the overall family <a href="#">Out-of-Pocket Limit</a> has been met. The medical and prescription out-of-pocket limits accumulate separately.
What is not included in the <a href="#">Out-of-Pocket Limit</a> ?	<a href="#">Premiums</a> , <a href="#">Balance Billing Charges</a> , <a href="#">Services not Covered by this Plan</a> , <a href="#">Fees above RBP</a> and/or <a href="#">UCR</a>		Even though you pay these expenses, they don't count towards the <a href="#">Out-of-Pocket Limit</a> .
Will you pay less if you use a <a href="#">Network Provider</a> ?	Not Applicable		This <a href="#">Plan</a> does not use a <a href="#">Provider Network</a> . You may receive covered services from any provider.
Are there prescription services?	Yes		Prescription services are available through PlanstinRX. The help desk can be reached at 435-893-7735. Start using all features of your prescription card by going to <a href="http://planstinrx.com">planstinrx.com</a> .
Do you need a <a href="#">Referral</a> to see a <a href="#">Specialist</a> ?	No		You can see any <a href="#">Specialist</a> you choose without a <a href="#">Referral</a> .

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care <a href="#">Provider's office or clinic</a>	<a href="#">Primary Care</a> Visit to Treat an Injury or Illness	20% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates.  <a href="#">Preventive Services</a> , as outlined by the ACA and shown on <a href="http://healthcare.gov">healthcare.gov</a> , will be paid at 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan pays <a href="#">UCR</a> rates. You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. If you receive a bill from a provider for Preventive Services, please call Planstin Member Services at 888-920-7526.
	<a href="#">Specialist</a> Visit	20% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Preventive Care/Screening/Immunization</a>	No Charge	
If you have a test	<a href="#">Diagnostic Test</a> (X-Ray)	20% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates.
	Lab/Bloodwork	20% Coinsurance <b>AFTER</b> Deductible is Met	
	Imaging (CT/PET Scans, Ultrasounds, MRIs)	20% Coinsurance <b>AFTER</b> Deductible is Met	
If you need drugs to treat your illness or condition More information about <a href="#">Prescription Drug</a> discounts is available at <a href="http://planstinrx.com">planstinrx.com</a>	Tier 1 -Generic	20% Coinsurance <b>AFTER</b> Deductible is Met	After deductible is met, plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Retail: Covers up to a 30-day supply. Mail Order: Covers up to a 90-day supply. Coverage is limited to FDA-approved prescription drugs. If brand named drugs are used when a generic is available, the member must pay the difference in cost plus the applicable coinsurance. Some drugs may require a prior authorization or step therapy. Specialty Drugs subject to medical necessity requirements. <b>*Plan pays a maximum of \$500 per Specialty RX. Cost of Specialty RX over the \$500 max plan limit will be the responsibility of the member and will not be applied to the member's deductible or OOP.</b>
	Tier 2 - Preferred Brand	20% Coinsurance <b>AFTER</b> Deductible is Met	
	Tier 3 - Non-Preferred Brand	20% Coinsurance <b>AFTER</b> Deductible is Met	
	Tier 4 – <a href="#">Specialty</a>	20% Coinsurance <b>AFTER</b> Deductible is Met*	
If you have outpatient surgery	Facility Fee / ASC	20% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions.
	Physician/Surgeon Fees	20% Coinsurance <b>AFTER</b> Deductible is Met	
If you need immediate medical attention	<a href="#">Emergency Room Care</a>	20% Coinsurance <b>AFTER</b> Deductible is Met	<b>EMERGENCIES ONLY.</b> After <a href="#">Deductible</a> , plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates.
	<a href="#">Emergency Medical Transportation</a>	20% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Urgent Care</a>	20% Coinsurance <b>AFTER</b> Deductible is Met	Applies to <b>URGENT CARE FACILITIES ONLY.</b> After <a href="#">Deductible</a> , plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates.

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility Fee (i.e., Hospital Room)	20% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions.
	Physician/Surgeon fees	20% Coinsurance <b>AFTER</b> Deductible is Met	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	20% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions.
	Inpatient Services	20% Coinsurance <b>AFTER</b> Deductible is Met	
If you are pregnant	Office Visits	20% Coinsurance <b>AFTER</b> Deductible is Met	After <a href="#">Deductible</a> , plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions.
	Childbirth / Delivery Professional Services	20% Coinsurance <b>AFTER</b> Deductible is Met	
	Childbirth / Delivery Facility Services	20% Coinsurance <b>AFTER</b> Deductible is Met	
If you need help recovering or have other special health needs	<a href="#">Home Health Care</a>	20% Coinsurance <b>AFTER</b> Deductible is Met	<p>Home Health Care: Limit of 60 Visits per Member per Plan Year  Rehabilitation Services &amp; Habilitation Services: Limit of 120 Visits (Combined) per Member per Plan Year and Includes Physical Therapy, Occupational Therapy &amp; Speech Therapy  Skilled Nursing Care: Limit of 120 Days per Member per Plan Year  Durable Medical Equipment: Limited to \$1,000 per Item/Service per Plan Year</p> <p>After <a href="#">Deductible</a>, plan pays 80% of Referenced Based Pricing (RBP) rates (150% of Medicare reimbursement rates). In the absence of a RBP rate, plan pays <a href="#">UCR</a> rates. Coverage is limited to items and services that are deemed medically necessary and may be subject to limitations and conditions.</p>
	<a href="#">Rehabilitation Services</a>	20% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Habilitation Services</a>	20% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Skilled Nursing Care</a>	20% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Durable Medical Equipment</a>	20% Coinsurance <b>AFTER</b> Deductible is Met	
	<a href="#">Hospice Services</a>	20% Coinsurance <b>AFTER</b> Deductible is Met	
	Chiropractor Visits *Limit 12 Visits per Member, per Plan Year	20% Coinsurance <b>AFTER</b> Deductible is Met	
If your child needs dental or eye care	Children's Vision Acuity Screening	No Charge	Plan pays 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan pays <a href="#">UCR</a> rates.
	Children's Glasses	Not Covered	
	Children's Fluoride Varnish	No Charge	Plan pays 150% of Medicare reimbursement rates. In the absence of a Medicare rate, plan pays <a href="#">UCR</a> rates.

[\* For more information about limitations and exceptions, see the plan or policy document at [planstin.com/resources](http://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](#).)

- Abortion
- Acupuncture
- Bariatric Surgery
- Dental Care (Adult)
- Experimental/Investigational Services
- Hearing Aids
- Home Traction Units
- Infertility/Reproductive Treatment
- Immunization for Anthrax, BCG, Cholera, Plague, Typhoid and Yellow Fever
- Laser Assisted in Situ Keratomileusis (LASIK)
- Long Term Care
- Non-Emergency Care when Traveling Outside the US
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Services a Third-Party is Responsible For
- Services Related to Certain Illegal Activities
- Services that are Not Medically Necessary
- Sexual Dysfunction
- Temporomandibular Joint Dysfunction (TMJ)
- Weight Loss Programs

### Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your [Plan](#) document.)

- Chiropractic visits limited to 12 visits per member per plan year and is limited to items and services that are medically necessary and may be subject to limitations.
- Cosmetic Surgery – Please refer to Summary Plan Description for a complete list of exclusions and limitations.

**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 at 888-920-7526 or [member@planstin.com](mailto: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](http://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 at 888-920-7526 or [member@planstin.com](mailto: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? YES

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](#).

### 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.

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## 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 Pre-Natal Care and a Hospital Delivery)

■ The Plan's Overall Deductible	\$5,000
■ Specialist Visit [Coinsurance]	20%
■ Imaging [Coinsurance]	20%
■ Lab/Bloodwork [Coinsurance]	20%
■ Hospital (Facility) [Coinsurance]	20%

**This EXAMPLE event includes services like:**

Specialist Office Visits (*Prenatal Care*)  
Imaging (*Ultrasounds*)  
Diagnostic Tests (*Bloodwork Labs*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services (*Including Anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$1,540
<i>What is NOT Covered</i>	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$6,640</b>

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

■ The Plan's Overall Deductible	\$5,000
■ Specialist Visit [Coinsurance]	20%
■ Lab/Bloodwork [Coinsurance]	20%
■ Durable Medical Equipment [Coinsurance]	20%

**This EXAMPLE event includes services like:**

Specialist Office Visits (*Including Disease Education*)  
Diagnostic Tests (*Bloodwork Labs*)  
Durable Medical Equipment (*Glucose Meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$120
<i>What is NOT Covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$5,120</b>

### Mia's Simple Fracture (Emergency Room Visit and Follow Up Care)

■ The Plan's Overall Deductible	\$5,000
■ Specialist Visit [Coinsurance]	\$0
■ ER Facility Services [Coinsurance]	\$0
■ Durable Medical Equipment [Coinsurance]	\$0
■ Rehab/Physical Therapy [Coinsurance]	\$0

**This EXAMPLE event includes services like:**

Rehabilitation Specialist Services (*Physical Therapy*)  
Emergency Room Care (*Including Supplies*)  
Emergency Room Diagnostic Tests (*X-Ray*)  
Durable Medical Equipment (*Crutches*)

<b>Total Example Cost</b>	<b>\$4,300</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$4,300
Copayments	\$0
Coinsurance	\$0
<i>What is NOT Covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$4,300</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.