CARE+ COPAY

Accessible care at an affordable price.

COMPREHENSIVE COVERAGE

PLAN SUMMARY

Your health plan covers essential health benefits and allows you to see specialists without a referral. There are no limits on pre-existing conditions for covered services, and the deductible is waived for copay services. Your plan includes complimentary care coordination services to help you find providers and potentially reduce costs by up to 50%. Contact the Care Coordination team at **coordination@planstin.com**.

30% COINSURANCE

PLAN OPTIONS

	Deductible		Out-of-Pocket Max	
1500	$1,500 Ind	$3,000 Fam	$3,100 Ind	$6,500 Fam
2500	$2,500 Ind	$5,000 Fam	$5,100 Ind	$10,500 Fam
3500	$3,500 Ind	$7,000 Fam	$7,100 Ind	$14,500 Fam
	Rx Deductible		**Rx Out-of-Pocket Max**	
All Levels	$1,000 Ind	$2,000 Fam	$1,200 Ind	$2,100 Fam

NO NETWORK

Open Access Plans

FAIR-PRICE HEALTHCARE

With no network, you'll have more provider options. The plan pays claims based on the most reasonable rates for your area. To learn more visit planstin.com/help-center.

COPAYS WITH DEDUCTIBLE WAIVED

COPAYS

Service	Copay	Service	Copay
Primary Care Visit	$50	Specialist Care Visit	$100
Urgent Care Visit	$100	Emergency Care	$500

VIRTUAL CARE

TELEHEALTH

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

PRESCRIPTION MEMBERSHIP

PRESCRIPTIONS

Prescription coverage up to $5,000 per Rx/month, home delivery (required for recurring orders), and significant discounts. Visit rxvalet.com to get started.

Prescription Tier	Retail (First Fill)	Mail Order (All Refills)
Tier 1: Generic	$10	$20
Tier 2: Preferred Brand	$50	$100
Tier 3: Non-Preferred Brand	$100	$100
Tier 4: Specialty	30% coinsurance after Rx deductible	

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 Member Services 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 https://www.healthcare.gov/glossary or call 888-920-7526 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	MEDICAL $3,500 / Individual or $7,000 / Family	PHARMACY $1,000 / Individual or $2,000 / Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Care Coordination is available to assist in finding lower-cost providers.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive care is covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. 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?	MEDICAL $7,100 / Individual or $14,500 / Family	PHARMACY $1,200 / Individual or $2,100 / Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, services not covered by this plan, fees above RBP rates and/or UCR rates.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Not Applicable		This plan does not use a provider network. You can receive covered services from any provider. Care Coordination is available to assist in finding lower-cost providers. When utilized, Care Coordination may reduce applicable copays up to 50%.
Do you need a referral to see a specialist?	No		You can see the specialist you choose without a referral.

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.
All covered services are paid at 150% of Medicare reimbursement rates (RBP). In the absence of a Medicare rate the plan will pay UCR.

Common Medical Event	Services You May Need	What You Will Pay Out-of-Network Provider (this plan does not use a network)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay/visit Deductible does not apply.	Plan will pay up to $250 max/visit. Additional charges are member responsibility, will not be applied to deductible or out-of-pocket limits. Primestin Virtual Care is included at no charge.
	Specialist visit	$100 copay/visit Deductible does not apply.	Plan will pay up to $375 max/visit. Additional charges are member responsibility, will not be applied to deductible or out-of-pocket limits.
	Preventive care/screening/ immunization	No Charge	You may have to pay for services that aren't preventive. Ask your provider, then check what your plan will pay for. **If you receive a bill for preventive services, call Member Services at (888) 920-7526.**
If you have a test	Diagnostic test (x-ray, blood work)	Tier I: $50 copay/x-ray and $20 copay/lab Tier II: $200 copay/x-ray and $50 copay/lab Deductible does not apply.	Tier I: Performed in a physician's office or free-standing facility. Tier II: Performed in a hospital or hospital-affiliated outpatient-facility. The plan pays up to $325/x-ray and $125/lab. Additional charges are member responsibility and will not be applied to deductible or out-of-pocket limits.
	Imaging (CT/PET scans, MRIs)	Tier I: $350 copay/test Tier II: $500 copay/test Deductible does not apply.	Tier I: Performed in a physician's office or free-standing facility. Tier II: Performed in a hospital or hospital-affiliated outpatient-facility. The plan pays up to $1,000/test. Additional charges are member responsibility and will not be applied to deductible or out-of-pocket limits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at PlanstinRx.com	Tier I: Generic drugs	$10 copay (retail) and $20 copay (mail order)	Rx deductible: $1,000 individual / $2,000 family. Rx out-of-pocket max: $1,200 individual / $2,100 family. ACA preventive drugs covered at 100%. First 30-day fill available at retail; all 30+ day refills must be through mail order. Drugs are covered up to **$5,000/month**; costs beyond this are the member's responsibility and do not count toward the deductible or out-of-pocket limits.
	Tier II: Preferred brand drugs	$50 copay (retail) and $100 copay (mail order)	
	Tier III: Non-preferred brand drugs	$100 copay (retail) and $100 copay (mail order)	
	Tier IV: Specialty drugs	30% Coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	This plan does not cover some types of facility charges. See Section IV of the Summary Plan Description for more exclusion information.
	Physician/surgeon fees	30% Coinsurance	See Section IV of the Summary Plan Description for more details.
	Emergency room care	$500 copay/visit	**Only covered in an emergency medical event.** See Section VI of the

* For more information about limitations and exceptions, see the plan or policy document at Benefit Documents | Planstin Administration

Common Medical Event	Services You May Need	What You Will Pay Out-of-Network Provider (this plan does not use a network)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention		Deductible does not apply.	Summary Plan Description for more details.
	Emergency medical transportation	$500 copay/visit Deductible does not apply.	**Only covered in an emergency medical event.** See Section VI of the Summary Plan Description for more details.
	Urgent care	$100 copay/visit Deductible does not apply.	Plan will pay up to $375 max/visit at Urgent care facilities only. Additional charges are member responsibility and will not be applied to deductible or out-of-pocket limits.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	Coverage is limited to items and services that are deemed medically necessary and may be subject to limitation and conditions.
	Physician/surgeon fees	30% Coinsurance	Coverage is limited to items and services that are deemed medically necessary and may be subject to limitation and conditions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% Coinsurance	Coverage is limited to items and services that are deemed medically necessary and may be subject to limitation and conditions.
	Inpatient services	30% Coinsurance	Coverage is limited to items and services that are deemed medically necessary and may be subject to limitation and conditions.
If you are pregnant	Office visits	$50 copay/visit Deductible does not apply.	Cost sharing does not apply for preventive services. Plan will pay up to $375/visit. Depending on the type of services, a copayment or deductible may apply.
	Childbirth/delivery professional services	30% Coinsurance	See Section VI of the Summary Plan Description for more details.
	Childbirth/delivery facility services	30% Coinsurance	See Section VI of the Summary Plan Description for more details.
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	60 visit limit per plan year. Limits are waived for Care Coordinated visits.
	Rehabilitation services	30% Coinsurance	120 visit limit (combined with habilitation services) per plan year. Limits are waived for Care Coordinated visits.
	Habilitation services	30% Coinsurance	120 visit limit (combined with rehabilitation services) per plan year. Limits are waived for Care Coordinated visits.
	Skilled nursing care	30% Coinsurance	120-day limit per plan year. Limits are waived for Care Coordinated visits.
	Durable medical equipment	30% Coinsurance	$1,250 limit per Item/Service per plan year.
	Hospice services	30% Coinsurance	Covered if prerequisites are met. See Section VI of the SPD for details.

Common Medical Event	Services You May Need	What You Will Pay Out-of-Network Provider (this plan does not use a network)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	No Charge	No Coverage for vision care, except as otherwise covered in Section VI of the Summary Plan Description.
	Children's glasses	Not Covered	Contacts, lenses, and frames are excluded.
	Children's dental check-up	No Charge	No Coverage for dental care, except as otherwise covered in Section VI of the Summary Plan Description.

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
- Bariatric Surgery
- Dental Care (Adult)
- Experimental/Investigational Services
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Cosmetic Surgery
- Routine Eye Care (Adult)
- Routine Foot Care
- Services that are not Medically Necessary
- Sexual Dysfunction
- Weight Loss Programs

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

- Chiropractic Care

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? Yes
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.

* For more information about limitations and exceptions, see the plan or policy document at Benefit Documents | Planstin Administration

[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, kwiijigo 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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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 Care Coordinated pre-natal care and a hospital delivery)

The Plan's Overall Deductible	**$3,500**
Specialist Visit Copayment	**$25**
Hospital (Facility) Coinsurance	**15%**
Other Coinsurance	**15%**

This EXAMPLE event includes services like:
Specialist Office Visits (Prenatal Care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic Tests (Imaging and Laboratory)

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$400
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,160**

Managing Joe's Type 2 Diabetes
(a year of routine Care Coordinated care of a well- controlled condition)

The Plan's Overall Deductible	**$3,500**
Specialist Visit Copayment	**$50**
Hospital (Facility) Coinsurance	**15%**
Other Coinsurance	**15%**

This EXAMPLE event includes services like:
Primary Care Physician Office Visits (Including Disease Education)
Diagnostic Tests (Laboratory)
Prescription Drugs
Medical Supplies

Total Example Cost	**$5,700**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,800
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,820**

Mia's Simple Fracture
(Care Coordinated emergency room visit and follow up care)

The Plan's Overall Deductible	**$3,500**
Specialist Visit Copayment	**$50**
Hospital (Facility) Coinsurance	**15%**
Other Coinsurance	**15%**

This EXAMPLE event includes services like:
Emergency Room Care (Including Medical Supplies)
Diagnostic Test (Imaging)
Durable Medical Equipment
Rehabilitation Services (Physical Therapy)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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