CARE+ DIRECT

More care, less hassle.

COMPREHENSIVE COVERAGE

PLAN SUMMARY

Your health plan includes coverage for a comprehensive set of essential health benefits, an assigned direct primary care (DPC) clinic, and care coordination services. When you use care coordination before receiving care, you may be eligible for no-cost, deductible-free care. Contact the Care Coordination team at **coordination@planstin.com**.

DEDUCTIBLES & LIMITS

Deductibles			Out-of-Pocket Limits	
Individual	$3,500 Medical*	$1,000 Rx	$10,000 Medical	$1,200 Rx
Family	$7,000 Medical*	$2,000 Rx	$20,000 Medical	$2,100 Rx

**Deductible waived when using care coordination before receiving care.*

NO-CHARGE SERVICES

CARE COSTS

Covered Service	With Care Coordination	Without Care Coordination	Payout Limits
Preventive Care	$0	$0	NA
Primary Care Visit	$0 - With Assigned DPC	20% Coinsurance	$150 / Visit
Specialist Care Visit	$0	20% Coinsurance	$300 / Visit
Diagnostic X-ray	$0	20% Coinsurance	$250 / X-ray
Diagnostic Lab Work	$0	20% Coinsurance	$100 / Lab
Specialty Imaging	$0	20% Coinsurance	$1,000 / Test
Urgent Care	$0 - With Assigned DPC	20% Coinsurance	$300 / Visit
Other Covered Services	$0	20% Coinsurance	See SBC

PRESCRIPTIONS

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/sbc-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. The deductible, copays, and coinsurance may be waived when using Care Coordination, as well as plan limits.
Are there services covered before you meet your deductible?	Yes. Preventive care and any service included in the DPC 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 $10,000 / Individual or $20,000 / 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. However, you will pay less if you use a provider in the plan's Direct Primary Care (DPC) system. You will pay the most if you use a non-DPC 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 DPC provider might use a non-DPC provider for some services (such as lab work). Check with your provider before you get services. Care Coordination is available to assist in finding lower-cost providers.
Do you need a referral to see a specialist?	No		You can see the specialist you choose without a referral.

SAMPLE

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		Limitations, Exceptions, & Other Important Information
		Care Coordinated Services	Other Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge with Direct Primary Care Provider	10% Coinsurance After Deductible is Met	Plan will pay up to $150 max per visit. Additional charges are member responsibility, will not be applied to deductible or out-of-pocket limits. Primestin Virtual Care is available for no charge.
	Specialist visit	No Charge	10% Coinsurance After Deductible is Met	Plan will pay up to $300 max per visit. Additional charges are member responsibility, will not be applied to deductible or out-of-pocket limits.
	Preventive care/screening/ immunization	No Charge	No Charge	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. **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)	No Charge	10% Coinsurance After Deductible is Met	The plan pays up to $250/x-ray and $100/lab. Additional charges are member responsibility and will not be applied to deductible or out-of-pocket limits.
	Imaging (CT/PET scans, MRIs)	No Charge	10% Coinsurance After Deductible is Met	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	Generic drugs	$10 copay (retail) and $20 copay (mail order)		RX deductibles are $1,000 (individual) and $2,000 (family). RX out-of-pocket limits are $1,200 (individual) and $2,100 (family). ACA Preventive drugs are covered 100%. First 30-day fill available at retail; all 30+ day refills must be through mail order. Plan will pay up to **$5,000 monthly max per prescription.** Additional costs are the member's responsibility and will not be applied to the deductible or to the out-of-pocket limits.
	Preferred brand drugs	$50 copay (retail) and $100 copay (mail order)		
	Non-preferred brand drugs	$100 copay (retail) and $100 copay (mail order)		
	Specialty drugs	30% Coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	10% Coinsurance After Deductible is Met	This plan does not cover some types of facility charges. Deductible is waived when using Care Coordination. See the Summary Plan Description for more information.

SAMPLE

* 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		Limitations, Exceptions, & Other Important Information
		Care Coordinated Services	Other Provider	
	Physician/surgeon fees	No Charge	10% Coinsurance After Deductible is Met	Deductible is waived when using Care Coordination. See the Summary Plan Description for details about services that may not be covered as part of outpatient surgery.
If you need immediate medical attention	Emergency room care	Not Covered	10% Coinsurance After Deductible is Met	**Only covered in an emergency medical event.** See the Summary Plan Description for more details.
	Emergency medical transportation	Not Covered	10% Coinsurance After Deductible is Met	**Only covered in an emergency medical event.** See the Summary Plan Description for more details.
	Urgent care	No Charge	10% Coinsurance After Deductible is Met	Coverage for Urgent care facilities only. Plan will pay up to $300 max/visit. 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)	No Charge	10% Coinsurance After Deductible is Met	Coverage is limited to items and services that are deemed medically necessary and may be subject to limitation and conditions.
	Physician/surgeon fees	No Charge	10% Coinsurance After Deductible is Met	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	No Charge	10% Coinsurance After Deductible is Met	Coverage is limited to items and services that are deemed medically necessary and may be subject to limitation and conditions.
	Inpatient services	No Charge	10% Coinsurance After Deductible is Met	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	No Charge	10% Coinsurance After Deductible is Met	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or deductible may apply.
	Childbirth/delivery professional services	No Charge	10% Coinsurance After Deductible is Met	See Section VI of the Summary Plan Description for more details.
	Childbirth/delivery facility services	No Charge	10% Coinsurance After Deductible is	See Section VI of the Summary Plan Description for more details.

SAMPLE

* 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		Limitations, Exceptions, & Other Important Information
		Care Coordinated Services	Other Provider	
			Met	
If you need help recovering or have other special health needs	Home health care	No Charge	10% Coinsurance After Deductible is Met	60 visit limit per plan year. Limits are waived for Care Coordinated visits.
	Rehabilitation services	No Charge	10% Coinsurance After Deductible is Met	120 visit limit (combined with habilitation services) per plan year. Limits are waived for Care Coordinated visits.
	Habilitation services	No Charge	10% Coinsurance After Deductible is Met	120 visit limit (combined with rehabilitation services) per plan year. Limits are waived for Care Coordinated visits.
	Skilled nursing care	No Charge	10% Coinsurance After Deductible is Met	120-day limit per plan year. Limits are waived for Care Coordinated visits.
	Durable medical equipment	No Charge	10% Coinsurance After Deductible is Met	$1,000 limit per Item/Service per plan year.
	Hospice services	No Charge	10% Coinsurance After Deductible is Met	Services are covered when prerequisites are satisfied. See the Summary Plan Description for more details.
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

SAMPLE

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

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.

[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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SAMPLE

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	$0
Hospital (Facility) Coinsurance	10%
Other Coinsurance	10%

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$3,500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions*	$60
The total Peg would pay is	**$4,060**

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

The Plan's Overall Deductible	$3,500
Specialist Visit Copayment	$0
Hospital (Facility) Coinsurance	10%
Other Coinsurance	10%

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$2,200
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions*	$20
The total Joe would pay is	**$2,820**

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

The Plan's Overall Deductible	$3,500
Specialist Visit Copayment	$0
Hospital (Facility) Coinsurance	10%
Other Coinsurance	10%

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

The plan would be responsible for the other costs of these EXAMPLE covered services.
Note: *When Care Coordination is used, members typically pay less out of pocket for covered medical services.*
**Prescription copays and over the counter drug costs accounted here remain as outlined in the prescription drug program.*

SAMPLE