

CARE+ DIRECT

With Sterling Medical



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 can access no-cost, deductible-free care. Questions? See the summary of benefits and coverage (SBC) for more details or call 888-920-7526.



DEDUCTIBLES
& LIMITS

Deductibles			Out-of-Pocket Limits	
Individual	\$3,500 Medical*	\$1,000 Rx	\$8,000 Medical	\$1,200 Rx
Family	\$7,000 Medical*	\$2,000 Rx	\$16,300 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	30% Coinsurance	\$150 / Visit
Specialist Care Visit	\$0	30% Coinsurance	\$300 / Visit
Diagnostic X-ray	\$0	30% Coinsurance	\$250 / X-ray
Diagnostic Lab Work	\$0	30% Coinsurance	\$100 / Lab
Specialty Imaging	\$0	30% Coinsurance	\$1,000 / Test
Urgent Care	\$0 - With Assigned DPC	30% Coinsurance	\$300 / Visit
Other Covered Services	\$0	30% Coinsurance	See SBC

PRESCRIPTIONS

Home delivery, discounts, and \$0 ACA preventive drugs. Visit planstinrx.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 \$500 Max Paid Per Rx, Per Month		



PLANSTINRX



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 ?	<table border="1"> <tr> <td><u>MEDICAL</u> \$3,500 / Individual or \$7,000 / Family</td> <td><u>PHARMACY</u> \$1,000 / Individual or \$2,000 / Family</td> </tr> </table>	<u>MEDICAL</u> \$3,500 / Individual or \$7,000 / Family	<u>PHARMACY</u> \$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 are waived when using Care Coordination as described in the Summary Plan Description.
<u>MEDICAL</u> \$3,500 / Individual or \$7,000 / Family	<u>PHARMACY</u> \$1,000 / Individual or \$2,000 / Family			
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 ?	<table border="1"> <tr> <td><u>MEDICAL</u> \$8,000 / Individual or \$16,300 / Family</td> <td><u>PHARMACY</u> \$1,200 / Individual or \$2,100 / Family</td> </tr> </table>	<u>MEDICAL</u> \$8,000 / Individual or \$16,300 / Family	<u>PHARMACY</u> \$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.
<u>MEDICAL</u> \$8,000 / Individual or \$16,300 / Family	<u>PHARMACY</u> \$1,200 / Individual or \$2,100 / Family			
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 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.		
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		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 Assigned 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 .
	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 specialty 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 regarding exclusions.

* 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 Met	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	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.

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

What You Will Pay				
Common Medical Event	Services You May Need	Care Coordinated Services	Other Provider	Limitations, Exceptions, & Other Important Information
	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 | • Infertility Treatment | • Routine Eye Care (Adult) |
| • Bariatric Surgery | • Long-term Care | • Routine Foot Care |
| • Dental Care (Adult) | • Non-emergency care when traveling outside the U.S. | • Services that are not Medically Necessary |
| • Experimental/Investigational Services | • Private-duty Nursing | • Sexual Dysfunction |
| • Hearing Aids | • Cosmetic Surgery | • 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.

[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.

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](#) \$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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles*	\$10
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions*	\$60
The total Peg would pay is	\$70

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1000
Copayments	\$0
Coinsurance*	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,700
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

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

Note: When Care Coordination is used, members typically pay \$0 out of pocket for covered medical services (deductibles, coinsurance, and copayments are waived).

*Prescription copays and over the counter drug costs accounted here remain as outlined in the PlanstinRx program.