

CARE+ HSA

Your healthcare, your way.



**COMPREHENSIVE
COVERAGE**

PLAN SUMMARY

Your health plan is HSA qualified, covers essential health benefits and allows you to see specialists without a referral. There are no limits on pre-existing conditions for covered services. Review your plan details, find plan documents, and get started with your benefits by scanning the code.



**30%
COINSURANCE**

OUT-OF-POCKET COSTS

Deductibles			Out-of-Pocket Limits	
Individual	\$3,500 Medical	\$1,000 Rx	\$7,100 Medical	\$1,200 Rx
Family	\$7,000 Medical	\$2,000 Rx	\$14,500 Medical	\$2,100 Rx



**NO NETWORK
RESTRICTIONS**

FAIR-PRICE HEALTHCARE

This plan gives you the freedom to see any healthcare provider, without worrying about network limitations. The plan pays for claims based on the most reasonable or fair rates for your area. To learn more about this reference-based pricing, [click here](#).



**OPTIONAL
HSA**

HEALTH SAVINGS ACCOUNT

Your plan allows for optional deposits into an HSA. If you choose to use this new HSA account, you will receive a debit card that can be used for qualified HSA expenses. To learn more about qualified HSA purchases, go to planstin.com/HSA.



**PLANSTINRX
MEMBERSHIP**

PRESCRIPTIONS

Prescription Tier	Coinsurance	Details
Tier 1: Generic	30%	After Deductible
Tier 2: Preferred Brand	30%	After Deductible
Tier 3: Non-Preferred Brand	30%	After Deductible
Tier 4: Specialty	30%	After Deductible \$500 max payout per Rx/month

Prescription coverage, home delivery, and significant discounts on brand name and specialty medications. Visit planstinrx.com to get started.

CARE+ HSA

Su atención médica, a su manera.



**COBERTURA
INTEGRAL**

RESUMEN DEL PLAN

Su plan de salud cumple con los requisitos de la HSA, cubre beneficios de salud esenciales y le permite ver especialistas sin una derivación. No existen límites en condiciones preexistentes para los servicios cubiertos. Revise los detalles de su plan, encuentre los documentos del plan y comience con sus beneficios escaneando el código.



**30 % DE
COSEGURO**

GASTOS DE SU PROPIO BOLSILLO

	Deducibles		Límites de gastos de su propio bolsillo	
Individual	\$3,500 para gastos médicos	\$1,000 para recetas médicas	\$7,100 para gastos médicos	\$1,200 para recetas médicas
Familiar	\$7,000 para gastos médicos	\$2,000 para recetas médicas	\$14,500 para gastos médicos	\$2,100 por recetas médicas



**SIN
RESTRICCIONES
DE RED**

ATENCIÓN MÉDICA A PRECIO JUSTO

Este plan le da la libertad de consultar a cualquier proveedor de atención médica, sin preocuparse por las limitaciones de la red. El plan paga los reclamos basados en las tarifas más razonables o justas para su área. Para obtener más información sobre estos precios basados en referencias, [haga clic aquí](#).



HSA OPCIONAL

CUENTA DE AHORROS PARA LA SALUD

Su plan permite depósitos opcionales en una HSA. Si decide utilizar esta nueva cuenta HSA, recibirá una tarjeta de débito que podrá utilizar para gastos calificados de la HSA. Para obtener más información sobre las compras calificadas de HSA, visite planstin.com/HSA.



**MEMBRESÍA
PLANSTINRX**

RECETAS MÉDICAS

Nivel de receta	Coseguro	Detalles
Nivel 1: Genérico	30 %	Después del deducible
Nivel 2: Marca preferida	30 %	Después del deducible
Nivel 3: Marca no preferida	30 %	Después del deducible
Nivel 4: Especialidad	30 %	Después del deducible Pago máximo de \$500 por receta médica/mes

Cobertura de recetas médicas, entrega a domicilio y descuentos significativos en medicamentos de marca y de especialidad. Visite planstinrx.com para comenzar.



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 ?	\$3,500 / Individual or \$7,000 / 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 ?	\$7,100 / Individual or \$14,500 / 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.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .



All [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	10% Coinsurance	Plan will pay up to \$150 max/visit. Additional charges are member responsibility, will not be applied to deductible or out-of-pocket limits .
	Specialist visit	10% Coinsurance	Plan will pay up to \$300 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 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)	10% Coinsurance	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 \$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)	10% Coinsurance	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	Generic drugs	30% Coinsurance	ACA preventive drugs covered at 100%. Specialty drugs covered up to \$500/month ; costs beyond this are the member's responsibility and do not count toward the deductible or out-of-pocket limits .
	Preferred brand drugs	30% Coinsurance	
	Non-preferred brand drugs	30% Coinsurance	
	Specialty drugs	30% Coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	This plan does not cover certain facility charges. See the Summary Plan Description for details about exclusions.
	Physician/surgeon fees	10% Coinsurance	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	10% Coinsurance	Only covered in an emergency medical event. See the Summary Plan Description for more details.
	Emergency medical	10% Coinsurance	Only covered in an emergency medical event. See the Summary Plan

* 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
	transportation		Description for more details.
	Urgent care	10% Coinsurance	Coverage applies to 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)	10% Coinsurance	Inpatient services are covered when medically necessary .
	Physician/surgeon fees	10% Coinsurance	Inpatient care is covered when medically necessary .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance	Services must be medically necessary . See your Summary Plan Description for more information regarding exclusions.
	Inpatient services	10% Coinsurance	See the Summary Plan Description for details regarding exclusions.
If you are pregnant	Office visits	10% Coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment or deductible may apply.
	Childbirth/delivery professional services	10% Coinsurance	See Section VI of the Summary Plan Description for more details.
	Childbirth/delivery facility services	10% 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	10% Coinsurance	60 visit limit per plan year.
	Rehabilitation services	10% Coinsurance	120 visit limit (combined with habilitation services) per plan year.
	Habilitation services	10% Coinsurance	120 visit limit (combined with rehabilitation services) per plan year.
	Skilled nursing care	10% Coinsurance	120-day limit per plan year.
	Durable medical equipment	10% Coinsurance	\$1,000 limit per Item/Service per plan year.
	Hospice services	10% Coinsurance	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.

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

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
- 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 (12 visit annual limit)
- Cosmetic Surgery

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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response,

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

including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 in-network pre-natal care and a hospital delivery)

- The [Plan's Overall Deductible](#) \$3,500
- [Specialist Visit Coinsurance](#) 10%
- 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 (Imaging and Laboratory)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,460

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [Plan's Overall Deductible](#) \$3,500
- [Specialist Visit Coinsurance](#) 10%
- Hospital (Facility) [Coinsurance](#) 10%
- Other [Coinsurance](#) 10%

This EXAMPLE event includes services like:

Primary Care Physician Office Visits (Including Disease Education)
 Diagnostic Tests (Laboratory)
 Prescription Drugs
 Medical Supplies

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$800
The total Joe would pay is	\$4,400

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [Plan's Overall Deductible](#) \$3,500
- [Specialist Visit Coinsurance](#) 10%
- Hospital (Facility) [Coinsurance](#) 10%
- Other [Coinsurance](#) 10%

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:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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.