

Core Management Resources Employee Healthcare Plan

Open Enrollment Quick Reference Summary

Effective February 1, 2020

Medical Coverage

PREMIUMS (per pay period)

Employee	\$13.75
Employee + Child(ren)	\$63.25
Employee + Spouse	\$118.25
Family	\$178.75

Deductibles, Coinsurance And Maximums	In-Network Benefit	Out-of-Network Benefit
Calendar Year Deductible		
– Individual	\$500	\$500
– Family	\$1,500	\$1,500
Coinsurance	80%	60%
Lifetime Maximum	Unlimited	Unlimited
Maximum Out-of-Pocket *		
– Individual	\$5,000	\$10,000
– Family	\$10,000	\$30,000

*The following do not apply to maximum out-of-pocket: deductibles, copayment amounts, non-emergency room copayments, and non-covered items. Amounts satisfied toward the out-of-network, out-of-pocket limit will also be applied toward the in-network, out-of-pocket limit. Amounts satisfied toward the in-network, out-of-pocket limit will not be applied toward the out-of-network, out-of-pocket limit.

Covered Services	In-Network Benefit	Out-of-Network Benefit
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Wellness Benefit – Adult and children over age one (1).

<ul style="list-style-type: none"> Annual exams to include office visits, mammograms, pap smears, prostate exams 	1 st \$500 payable at 100% (<i>not subject to deductible</i>). Charges after \$500, plan pays 80% after deductible.	Not covered
<ul style="list-style-type: none"> Eye exam 	\$100 calendar year maximum	Not covered

Illness or Injury

<ul style="list-style-type: none"> Doctor's office visit 	Plan pays 80% after \$25 copayment	Plan pays 60% after deductible
<ul style="list-style-type: none"> Chiropractic care (\$1,200 calendar year maximum) 	\$25 copayment	Plan pays 60% after deductible
<ul style="list-style-type: none"> Maternity physician services (prenatal, delivery, postpartum) 	Plan pays 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> Newborn nursery care (included as expense of the baby) 	Plan pays 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> Supplemental accident benefit 	1 st \$500 per accident payable at 100%, then plan pays 80% after deductible	1 st \$500 per accident payable at 100%, then plan pays 60% after deductible

Emergency Room Services

<ul style="list-style-type: none"> Hospital emergency room (per visit) 	\$150 copayment	\$150 copayment
<ul style="list-style-type: none"> Hospital "per admission" deductible 	no deductible	\$500 deductible

Inpatient / Outpatient Services

<ul style="list-style-type: none"> Preadmission testing 	Plan pays 100%	Plan pays 60% after deductible
<ul style="list-style-type: none"> Physician services (anesthesiologist, radiologist, pathologist) 	Plan pays 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> X-ray and lab services (performed in Doctor's Office) 	Plan pays 80% (<i>not subject to deductible</i>)	Plan pays 60% after deductible
<ul style="list-style-type: none"> X-ray and lab services (performed at Hospital or Free-standing Facility) 	Plan pays 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges 	Plan pays 80% after deductible	Plan pays 60% after deductible

Other Services – Calendar year maximums are combined between in-network and out-of-network

<ul style="list-style-type: none"> Mental or Nervous Disorder; Substance Abuse (In-Patient/ Out-Patient Hospital benefit – 10 days per year Out-Patient Office – 14 visits per year) 	Plan pays 80% after deductible	Plan pays 60% after deductible
<ul style="list-style-type: none"> Skilled Nursing Facility 	\$3,480 calendar year maximum	\$3,480 calendar year maximum
<ul style="list-style-type: none"> Home Health Care 	\$2,500 calendar year maximum	\$2,500 calendar year maximum
<ul style="list-style-type: none"> Hospice Care 	\$10,000 calendar year maximum	\$10,000 calendar year maximum
<ul style="list-style-type: none"> Air Ambulance 	Plan pays 60% after deductible	Plan pays 60% after deductible

PRESCRIPTION CO-PAYS (The greater of the flat-dollar copayment or coinsurance)	RETAIL PHARMACY (30-day supply only)	MAIL ORDER (60, 90-day supply)
GENERIC	\$10 or 20% cost of drug	\$20 or 25% cost of drug
PREFERRED	\$20 or 20% cost of drug	\$40 or 20% cost of drug
NON-PREFERRED	\$35 or 20% cost of drug	\$70 or 20% cost of drug
PRE-CERTIFICATION	<p>This Plan covers only charges that are Medically Necessary for the care and treatment of disease or injury. To determine Medical Necessity, Core Health Services (CHS) requires that you obtain advance approval (pre-certification) for scheduled inpatient and outpatient hospital treatment and all services performed in an Ambulatory Surgical Facility or Specialized Treatment Facility (Oncology Center, Dialysis Facility, etc.). Please call CHS to see if your Outpatient Procedure requires Pre-certification.</p> <ul style="list-style-type: none"> • Maternity (see separate Maternity Admissions) also requires notification. • Emergency services (see separate Emergency or Urgent Inpatient or Outpatient Admissions). <p>MUST BE REPORTED TO CORE WITHIN 48 HOURS.</p> <p>PENALTY FOR FAILURE OF PRE-CERTIFICATION IS \$500 FOR IN-NETWORK PROVIDER; \$1,000 FOR OUT-OF-NETWORK PROVIDER.</p>	
EXCLUSIONS	<p>If your spouse is offered medical insurance through their employer, they must elect to enroll in that coverage. You must complete the Spousal COB Questionnaire if you cover your spouse.</p> <p>Dependent coverage will end for all of a Covered Employee's Dependents on the date the Dependent reaches age 65.</p>	