CORE Management Resources: CORE

Coverage Period: 2/01/2016 – 1/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Coverage Levels | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.corehealthbenefis.com or by calling 1-888-741-2673.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person **/$1,500** family. Does not apply to in-network or out-of-network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$500** for Out-of-Network Facility per admission deductible.	You must pay all the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network providers **$5,000** person **/$15,000** family. For out-of-network providers **$10,000** person **/ $30,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, copayments, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes, **$2 million.**	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See **www.corehealthbenefits.com or call 1-888-741-2673** for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-741-2673 or visit us at www.corehealthbenefits.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.corehealthbenefits.com/Members.aspx or call 1-888-741-2673 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit and 20% coinsurance	40% coinsurance	——————none——————
	Specialist visit	$25 copay/visit and 20% coinsurance	40% coinsurance	
	Other practitioner office visit	$25 copay/visit for chiropractor	40% coinsurance after deductible for chiropractor	Calendar year maximum is $1,200.
	Preventive care/screening/immunization	see limitations	see limitations	Plan pays 100% of eligible expenses up to $500; eligible expenses exceeding $500; 20% coinsurance for in-network or 40% coinsurance for out-of-network., after the deductible has been met.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible (if not performed at health care provider's office or clinic)	40% coinsurance after deductible (if not performed at health care provider's office or clinic)	If performed during a visit to a health care provider, see above for benefit. Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.corehealthbenefits.com.	Generic drugs	**Retail**: $10 co-pay **OR** 20% cost of drug/prescription. **Mail order**: $20 co-pay **OR** 20% cost of drug/ prescription.	n/a	Copayment is the greater of the flat-dollar copayment or coinsurance. Retail pharmacy – 30 day supply only; Mail order – 90 day supply.
	Preferred brand drugs	**Retail**: $20 co-pay **OR** 20% cost of drug/ prescription. **Mail order**: $40 co-pay **OR** 20% cost of drug/prescription.	n/a	Copayment is the greater of the flat-dollar copayment or coinsurance. Retail pharmacy – 30 day supply only; Mail order – 90 day supply.
	Non-preferred brand drugs	**Retail**: $35 co-pay **OR** 20% cost of drug/ prescription. **Mail order**: $70 co-pay **OR** 20% cost of drug/prescription.	n/a	Copayment is the greater of the flat-dollar copayment or coinsurance. Retail pharmacy – 30 day supply only; Mail order – 90 day supply.
	Specialty drugs	n/a	n/a	see above categories
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$150 copayment per visit then 20% coinsurance	$150 copayment per visit then 40% coinsurance	Copayment is waived if an accident, or admitted within 24 hours, or true emergency.
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
	Physician/surgeon fee			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	None
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
	Substance use disorder outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	None
	Substance use disorder inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible	40% coinsurance after deductible	Available for Employee and Spouse **ONLY**. Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean).
	Delivery and all inpatient services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Must be reviewed and approved every 30 days.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required for occupational therapy, pulmonary therapy, pulmonary rehabilitation and speech therapy. Limit 25 visits.
	Habilitation services			
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Maximum 30 days per calendar year
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	All DME in excess of $500 require preauthorization by CORE.
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Must be reviewed and approved every 60 days
If your child needs dental or eye care	Eye exam	See Limitations	See Limitations	Maximum allowable for Eye Exam is $100 which is included in the Wellness Benefit of $500.
	Glasses	Not Covered	Not Covered	n/a

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	See Dental Plan
If you need outpatient dialysis	Dialysis treatment, including hemodialysis and peritoneal dialysis, appropriate drugs and monitoring	20% coinsurance after deductible, see Limitations and Exceptions	40% coinsurance after deductible, see Limitations and Exceptions	Charges may be based on negotiated amounts agreed to by the Provider, or "Usual and Reasonable" charges for either In-network or Out-of-network Providers. "Usual and Reasonable" charges reflect the actual amount paid for comparable services in the Provider's vicinity during the prior calendar year, adjusted for inflation. If you are not enrolled in Medicare, you may be balance billed by the Provider.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Dental care (Adult) for accidental injury, removal of tumors, removal of unerupted/impacted teeth, or correction of congenital abnormalities
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-741-2673. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-888-741-2673.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,632
- **Patient pays** $1,908

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$1,408
Limits or exclusions	$0
Total	**$1,908**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$120
Coinsurance	$280
Limits or exclusions	$0
Total	**$900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.