CORE Management Resources: Liberty Regional Medical Center Plan A1- Platinum
Coverage Period: 12/1/16 – 11/30/17

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

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.corehealthbenefits.com or by calling 1-888-741-2673.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Plan A1 Platinum** **$1,000** person/**$2,500** Family In-Network/ **$2,000** person/**$5,000** Family Out-of-Network Doesn't apply to In-Network Routine Annual Exam.	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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For In-Network providers **$2,500** person /**$5,000 annually** per family. For Out-of-Network Providers **Unlimited/ person**	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, 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?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers, see **www.corehealthbenefits.com or call 1-888-741-2673.**	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. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. 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**.

- **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	$10 Co-pay or $25 Co-pay	50% coinsurance after deductible	————————none————————
	Specialist visit	$30 Co-pay or $45 Co-Pay	50% coinsurance after deductible	————————none————————
	Other practitioner office visit	10% or 20% coinsurance after deductible	50% coinsurance after deductible	Chiropractic care Coverage is limited to 20 visits maximum. No coverage for Acupuncture.
	Routine Annual Exam/Screening/Immunization	No cost	50% coinsurance after deductible	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	No Cost or 20% after deductible	50% coinsurance after deductible	Prior authorization may be required for specific services.
	Imaging (CT/PET scans, MRIs)	No Cost or 20% after deductible	50% coinsurance after deductible	Prior authorization may be required for specific services

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	$10 co-pay (retail) **OR** $25 copay (mail order)	None	Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Preferred brand drugs	$25 co-pay (retail) **OR** $50 co-pay (mail order)	None	The greater of the flat-dollar co-payment or coinsurance. Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Non-preferred brand drugs	$50 co-pay (retail) **OR** $100 co-pay (mail order)	None	The greater of the flat-dollar co-payment or coinsurance. Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Specialty drugs	20% ($250 co-pay max) **OR** 20% ($750 co-pay max per 30-day supply) (mail order)	None	See above categories.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% **OR** 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Physician/surgeon fees	10% **OR** 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
If you need immediate medical attention	Emergency room services	$150 co-pay then 20% coinsurance after deductible	$150 co-pay then 20% coinsurance after deductible	Non-accident, non-emergency services is not covered. $200 co-pay plus 20% co-insurance, per admittance, (waived if admitted.)
	Emergency medical transportation	20% coinsurance after deductible	50% coinsurance after deductible	——————none——————

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
	Urgent care	$75 co-pay	$75 co-pay 50% coinsurance after deductible	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 10% **OR** Deductible then $200 Co-pay plus 20% coinsurance	Deductible then $600 Co-pay plus 50% coinsurance	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Physician/surgeon fee	10% **OR** 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% **OR** 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Mental/Behavioral health inpatient services	10% **OR** 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Substance use disorder outpatient services	10% **OR** 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Substance use disorder inpatient services	10% **OR** 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
If you are pregnant	Prenatal and postnatal care	10% **OR** 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean). 50% reduced benefits/coinsurance for noncompliance.

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
	Delivery and all inpatient services	10% **OR** 20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean), 50% reduced benefits/coinsurance for noncompliance.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	120-day calendar year maximum. Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	25 days per calendar year maximum. Preauthorization required.
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	30 days per calendar year maximum. Preauthorization required.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for all DME in excess of $500, penalty for noncompliance
	Hospice service	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
If your child needs dental or eye care	Eye exam	$25 co-pay	$50 co-pay	One (1) eye exam routine benefit per program year.
	Glasses	$25 co-pay plus cost that exceed plan	$50 co-pay plus cost that exceed plan	One (1) pair of lenses per program year. One (1) pair of frames every 24 months.
	Dental check-up	20% coinsurance	50% coinsurance	One (1) dental exam every six (6) months

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

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
- Dental (Adult)
- Hearing aids
- Infertility treatment
- Long-Term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- 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
- Private-duty nursing

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.

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** $6,360
- **Patient pays** $1,180

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	$220
Copays	$110
Coinsurance	$700
Limits or exclusions	$150
Total	**$1,180**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,900
- **Patient pays** $1,500

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	$280
Copays	$500
Coinsurance	$640
Limits or exclusions	$80
Total	**$1,500**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: 1-888-741-2673.

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.