

<b>Effective Date</b> 11/1/2018	<b>Health Plan</b> Core HMO	<b>Ref</b> RQ-124837
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This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

<b>Benefits</b>	<b>Inside Network</b>
<b>Plan deductible</b>	Individual deductible: \$200 per calendar year Family deductible: \$600 per calendar year
<b>Individual deductible carryover</b>	4th quarter carryover applies
<b>Plan coinsurance</b>	No plan coinsurance
<b>Out-of-pocket limit</b>	Individual out-of-pocket limit: \$2,000 Family out-of-pocket limit: \$6,000  Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:  All cost shares for covered services
<b>Pre-existing condition (PEC) waiting period</b>	No PEC
<b>Lifetime maximum</b>	Unlimited
<b>Outpatient services (Office visits)</b>	\$20 copay, deductible applies
<b>Hospital services</b>	<b>Inpatient services:</b> Deductible applies <b>Outpatient surgery:</b> \$20 copay, deductible applies
<b>Prescription drugs (some injectable drugs may be covered under Outpatient services)</b>	Preferred generic/preferred brand \$10/\$20 copay per 30 day supply
<b>Prescription mail order</b>	2 x prescription cost share per 90 day supply
<b>Acupuncture</b>	Covered up to 12 visits per calendar year \$20 copay, deductible applies
<b>Ambulance services</b>	Plan pays 80%, you pay 20%
<b>Chemical dependency</b>	<b>Inpatient:</b> Deductible applies <b>Outpatient:</b> \$20 copay, deductible applies
<b>Devices, equipment and supplies</b>	Covered at 50% <ul style="list-style-type: none"> <li>• Durable medical equipment</li> <li>• Orthopedic appliances</li> <li>• Post-mastectomy bras limited to two (2) every six (6) months</li> <li>• Ostomy supplies</li> <li>• Prosthetic devices</li> </ul>
<b>Diabetic supplies</b>	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
<b>Diagnostic lab and X-ray services</b>	<b>Inpatient:</b> Covered under Hospital services <b>Outpatient:</b> Deductible applies  High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.

<b>Emergency services</b> (copay waived if admitted)	\$75 copay at a designated facility \$75 copay at a non designated facility Deductible applies
<b>Hearing exams (routine)</b>	\$20 copay, deductible applies
<b>Hearing hardware</b>	Not covered
<b>Home health services</b>	Covered in full. No visit limit.
<b>Hospice services</b>	Covered in full
<b>Infertility services</b>	Not covered
<b>Manipulative therapy</b>	Covered up to 10 visits per calendar year without prior authorization \$20 copay, deductible applies
<b>Massage services</b>	See Rehabilitation services
<b>Maternity services</b>	<b>Inpatient:</b> Deductible applies <b>Outpatient:</b> \$20 copay, deductible applies. Routine care not subject to outpatient services copay.
<b>Mental Health</b>	<b>Inpatient:</b> Deductible applies <b>Outpatient:</b> \$20 copay, deductible applies
<b>Naturopathy</b>	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$20 copay, deductible applies
<b>Newborn Services</b>	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
<b>Obesity-related surgery (bariatric)</b>	Not covered
<b>Organ transplants</b>	Unlimited, no waiting period  <b>Inpatient:</b> Deductible applies <b>Outpatient:</b> \$20 copay, deductible applies
<b>Preventive care</b> Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full  Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.
<b>Rehabilitation services</b>  Rehabilitation visits are a total of combined therapy visits per calendar year	<b>Inpatient:</b> 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible applies <b>Outpatient:</b> 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. \$20 copay, deductible applies
<b>Skilled nursing facility</b>	Up to 60 days per calendar year, deductible applies
<b>Sterilization</b> (vasectomy, tubal ligation)	<b>Inpatient:</b> Deductible applies <b>Outpatient:</b> \$20 copay, deductible applies <b>Outpatient Surgery:</b> See Hospital services; Outpatient surgery section  Women's sterilization procedures are covered in full.
<b>Temporomandibular Joint (TMJ) services</b>	<b>Inpatient:</b> Deductible applies <b>Outpatient:</b> \$20 copay, deductible applies
<b>Tobacco cessation counseling</b>	Quit for Life Program - covered in full
<b>Routine vision care</b> (1 visit every 12 months)	\$20 copay, deductible waived
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered