Elliot Health System – Core Plan: Open Access Plus In-Network

Coverage Period: 07/01/2016 – 06/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Individual + Family | **Plan Type:** OAP

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 www.myCigna.com or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**For Tier 1 (Elliot Employed)** (Deductible applies to ambulatory surgery or inpatient services only.) **and Tier 2 (Elliot affiliated):** $750 individual / $1,500 individual + one / $2,250 family **For Tier 3 (Cigna Network):** $1,000 individual / $2,000 individual + one / $3,000 family Does not apply to in-network preventive care, in-network office visits, emergency room visits, urgent care facility visits and prescription drugs.	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. 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, for Retail prescription drugs (excluding River's Edge Pharmacy)	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. **Medical: Tier 1 (Elliot Employed)/Tier 1 (Elliot affiliated):** $3,000 individual / $6,000 individual + one/ $9,000 family **Medical: For Tier 3 (Cigna Network):** $3,500 individual / $7,000 individual + one / $10,500 family **Pharmacy:** $1,000 individual / $1,500 individual+1 / $2,000 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?	Premium, balanced-billed charges, and health care expenses this plan doesn't cover	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

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.myCigna.com [variable for specific website] or call 1-800-Cigna24	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.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance 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 co-insurance 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 participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		Tier 1 (Elliot employed)	Tier 2 (Elliot affiliated)	Tier 3 (Cigna Network)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay/visit	$35 co-pay/visit	$45 co-pay/visit	———————none———————
	Specialist visit	$40 co-pay/visit	$45 co-pay/visit	$50 co-pay/visit	———————none———————
	Other practitioner office visit	$40 co-pay/visit	$45 co-pay/visit	$50 co-pay/visit	Chiropractic and Rehabilitation Services is limited to 60 days annual max.
	Preventive care/screening / immunization	No charge	No charge	No charge	———————none———————

Common Medical Event	Services You May Need	Your cost if you use an Tier 1 (Elliot employed)	Tier 2 (Elliot affiliated)	Tier 3 (Cigna Network)	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————
Prescription drug coverage is provided by Caremark. More information about <u>prescription drug coverage</u> is available at www.Caremark.com.	Generic drugs	**Elliot Pharmacy at <u>River's Edge</u>** $10 co-pay (retail) / $20 co-pay (90 days)	N/A	$15 co-pay (retail) $30 co-pay/ (90 days)	Coverage is limited up to a 30-day supply (retail) and up to 90-day supply (90 days)
	Preferred brand-name drugs	**Elliot Pharmacy at <u>River's Edge</u>** $30 co-pay (retail) / $60 co-pay (90 days)	N/A	$40 co-pay (retail) / $80 co-pay (90 days)	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (90 days).
	Non-preferred brand-name drugs	**Elliot Pharmacy at <u>River's Edge</u>** $55 co-pay (retail) / $110 co-pay (90 days)	N/A	$70 co-pay (retail) / $140 co-pay (90 days)	Coverage is limited to a 30-day supply (retail) and up to a 90-day supply (90 days)
	Prescription Drug Deductible	No deductible	N/A	$50 Individual $100 Individual + 1 $150 Family	———————none———————
	Prescription Drug Out of Pocket Maximum	$1,000 Individual $1,500 Individual+1 $2,000 Family	N/A	$1,000 Individual $1,500 Individual+1 $2,000 Family	Tier 3 Deductible is included in the Tier 3 Out of Pocket Maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————
	Physician/surgeon fees	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————

Common Medical Event	Services You May Need	Your cost if you use an Tier 1 (Elliot employed)	Tier 2 (Elliot Affiliated)	Tier 3 (Cigna Network)	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-insurance after $150 per visit	20% co-insurance after $150 per visit	20% co-insurance after $150 per visit	Per visit co-pay is waived if admitted
	Emergency medical transportation	Not applicable	40% co-insurance	40% co-insurance	———————none———————
	Urgent care	20% coinsurance after $60 per visit	40% co-insurance after $90 per visit	40% co-insurance after $90 per visit	Per visit co-pay is waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————
	Physician/surgeon fee	20% co-insurance	20% co-insurance	20% co-insurance	———————none———————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 co-pay/office visit or 20% co-insurance other outpatient services	$30 co-pay/office visit or 20% co-insurance other outpatient services	$30 co-pay/office visit or 20% co-insurance other outpatient services	———————none———————
	Mental/Behavioral health inpatient services	20% co-insurance	20% co-insurance	20% co-insurance	———————none———————
	Substance use disorder outpatient services	$30 co-pay/office visit or 20% co-insurance other outpatient services	$30 co-pay/office visit or 20% co-insurance other outpatient services	$30 co-pay/office visit or 20% co-insurance other outpatient services	———————none———————
	Substance use disorder inpatient services	20% co-insurance	20% co-insurance	20% co-insurance	———————none———————
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————

Common Medical Event	Services You May Need	Your cost if you use an Tier 1 (Elliot employed)	Tier 2 (Elliot Affiliated)	Tier 3 (Cigna Network)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————
	Rehabilitation services	20% co-insurance	40% co-insurance	40% co-insurance	Coverage is limited to annual max. of: 60 days for Rehabilitation services; 36 days for Cardiac rehab services
	Habilitation services	Not Covered	Not Covered	Not Covered	———————none———————
	Skilled nursing care	20% co-insurance	40% co-insurance	40% co-insurance	Coverage is limited to 100 days annual max
	Durable medical equipment	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————
	Hospice service	20% co-insurance	40% co-insurance	40% co-insurance	———————none———————
If your child needs dental or eye care	Eye exam	$40 co-pay/visit	$40 co-pay/visit	$40 co-pay/visit	———————none———————
	Glasses	Not Covered	Not Covered	Not Covered	———————none———————
	Dental check-up	Not Covered	Not Covered	Not Covered	———————none———————

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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- Routine foot care, and
- 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.

- Bariatric Surgery
- Chiropractic
- Eye exam (Children)
- Infertility treatment
- Routine eye care (Adults)

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 1-800-Cigna24. 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 Cigna Customer service at 1800Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1866444EBSA (3272) or www.dol.gov/ebsa/healthreform or the New Hampshire Insurance Department at 18008523416. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: New Hampshire Department of Insurance at 8008523416. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,900
- **Patient pays** $ 2,640

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	$800
Co-pays	$100
Co-insurance	$1,710
Limits or exclusions	$30
Total	**$2,640**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,730
- **Patient pays** $1,670

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	$190
Co-pays	$1,200
Co-insurance	$0
Limits or exclusions	$280
Total	**$1,670**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.

Plan Name: Core Plan
KitTraK Catalog Number: SBM15465