Carespring Health Care Mgm. Benefit Plan: Gold Plan

Coverage Period: 05/01/2015 – 04/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs**Coverage for:** Employee + Dependents | **Plan Type:** Copay

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.customdesignbenefits.com or by calling 1-800-598-2929.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
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. **$4,000** person / **$8,000** 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, health care this plan doesn't cover and cost containment penalties.	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?	No.	This plan treats **providers** the same in determining payment for the same services.
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 4. 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**.)

- Your cost sharing does not depend on whether a provider is in a network.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit $0 if Christ Hospital	————————none————————
	Specialist visit	$20 copay/visit	————————none————————
	Other practitioner office visit	$20 copay/visit for chiropractor	$1,000/plan year limit for spinal manipulation
	Preventive care/screening/immunization	No charge	1/plan year limit for GYN/Pap; mammogram; prostate screening/PSA test; routine physical. 1 every 5 years limit for routine colonoscopy/ sigmoidoscopy.
If you have a test	Diagnostic test (x-ray, blood work)	$0	————————none————————
	Imaging (CT/PET scans, MRIs)	$150 copay/test for CT Scans $250 copay/test for MRI and PET Scans	————————none————————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.customdesignbenefits.com .	Generic drugs	Copays/prescription: Retail — $10 Mail Order — $10	Covers up to a 90-day supply
	Preferred brand drugs	Copays/prescription: Retail — $40 Mail Order — $40	Covers up to a 90-day supply
	Non-preferred brand drugs	Copays/prescription: Retail — $60 Mail Order — $60	Covers up to a 90-day supply
	Specialty drugs	25% coinsurance to $250/prescription	Covers up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	Precertification required unless done in Physician's office or payment reduced by $250
	Physician/surgeon fees	$0	

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$200 copay/visit	Copay waived if admitted
	Emergency medical transportation	$50 copay/use	——————none——————
	Urgent care	$20 copay/visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/stay	Precertification required or payment reduced by $250
	Physician/surgeon fee	$0	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit $0 if Christ Hospital	——————none——————
	Mental/Behavioral health inpatient services	$500 copay/stay	Precertification required or payment reduced by $250
	Substance use disorder outpatient services	$20 copay/visit $0 if Christ Hospital	——————none——————
	Substance use disorder inpatient services	$500 copay/stay	Precertification required or payment reduced by $250
If you are pregnant	Prenatal and postnatal care	$0	——————none——————
	Delivery and all inpatient services	$500 copay/stay	
If you need help recovering or have other special health needs	Home health care	$0	40 visits/plan year limit. Precertification required or payment reduced by $250
	Rehabilitation services	$50 copay/visit	45 visits/plan year limit each for occupational, physical and speech therapies.
	Habilitation services	$50 copay/visit	
	Skilled nursing care	$100 copay/day	60 days/plan year limit. Precertification required or payment reduced by $250
	Durable medical equipment	20% coinsurance	$2,500/device limit. Precertification required if over $1,200 or payment reduced by $250
	Hospice service	$0	$10,000/plan year limit.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge	Routine exam under preventive care
	Glasses	Not Covered	————————n/a————————
	Dental check-up	Not Covered	Dental benefits are covered under the dental plan which is included when you elect medical coverage.

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 care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Services performed at any Children's Hospital or its affiliated facility for members 18 or over

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 1-800-598-2929. 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 Custom Design Benefits at 1-800-598-2929 or customdesignbenefits.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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** $6,870
- **Patient pays** $670

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	$0
Copays	$520
Coinsurance	$0
Limits or exclusions	$150
Total	**$670**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,470
- **Patient pays** $930

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	$0
Copays	$600
Coinsurance	$250
Limits or exclusions	$80
Total	**$930**

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.