CORESOURCE
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FOUNDATION FOR ADVANCED EDUCATION IN THE SCIENCES

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference.

Medical Benefits

	Preferred Provider	***Nonpreferred Provider***
Deductible Per Plan Year		
Individual (Per Person)	N/A	$200
Family (Aggregate)	N/A	$400
	Preferred Provider	***Nonpreferred Provider***
Out-of-Pocket Expense Limit Per Plan Year (includes deductible)		
Individual (Per Person)	$1,500	$2,000
Family (Aggregate)	$3,000	$4,000

Amounts applied toward satisfaction of the ***preferred provider*** deductible and out-of-pocket expense limit may also be applied toward satisfaction of the ***nonpreferred provider*** deductible and out-of-pocket expense limit and vice versa.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a plan year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the plan year or until the ***maximum benefit*** has been reached.

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount*** , if applicable, otherwise % of ***negotiated rate***)
Inpatient Hospital	100%	80%
Outpatient Surgery/Ambulatory Surgical Facility	100%	80%

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount*** , if applicable, otherwise % of ***negotiated rate***)
Emergency Room Services	100% after $100 ***copay***	*100% after $100 ***copay***
Urgent Care Center	100% after $10 ***copay***	*100% after $10 ***copay***
Ambulance Services	100%	*100%
Physician Services		
Inpatient Visit	100%	80%
Office Visit		
Primary Care Physician	100% after $10 ***copay***	80%
Specialist	100% after $10 ***copay***	80%
Surgery	100%	80%
Allergy Injections	100%	80%
Pathology	100%	80%
Anesthesiology	100%	80%
Radiology	100%	80%
Diagnostic Services and Supplies		
Inpatient	100%	80%
Outpatient	100%	80%
MRI/CT/PET Scan	100%	80%
Second Surgical Opinion	100% after $10 ***copay***	80%
Extended Care Facility Limitation: 100 days ***maximum benefit*** per plan year	100%	80%

***** **Deductible Waived**

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Home Health Care	100%	80%
Hospice Care	100%	80%
Durable Medical Equipment	75%	75%
Prostheses/Orthotics	100%	80%
Routine Preventive Care/Wellness Benefits	100%	80%
Women's Preventive Services	100%	80%
Therapy Services (Physical, Speech, Occupational) Limitation: 30 visits ***maximum benefit*** per plan year	100% after $10 ***copay***	80%
Cardiac Therapy Limitation: 90 visits ***maximum benefit*** per plan year	100% after $15 ***copay***	80%
Respiratory Therapy Limitation: 1 program ***maximum benefit*** while covered under the plan	100% after $15 ***copay***	80%
All Other Therapies	100%	80%
Birthing Center	100%	80%
Chiropractic Care Limitation: 20 visits ***maximum benefit*** per plan year	100% after $10 ***copay***	80%
Hearing Aids (For dependent minor children) Limitation: one aid for each ear every 36 months	100%	*100%
Acupuncture Limitation: 20 visits ***maximum benefit*** per plan year	100% after $10 ***copay***	80%
Routine Vision Examination Limitation: 1 exam ***maximum benefit*** per plan year	100% After $10 ***copay***	Up to $33 Maximum Reimbursement

*** Deductible Waived**

Prescription Drug Benefits	
Pharmacy and Mail Order Options Out-of-Pocket Expense Limit Per Plan Year:	
Individual (Per Person)	$1,500
Family (Aggregate)	$3,000
Pharmacy Option	
Prescription Drug Card	100% after ***copay***
Copay	ACA Required Medications: $0 ***copay*** Generic: 34 day $5 ***copay*** 90 day $10 ***copay*** Single Source Brand Name: 34 day $10 ***copay*** 90 day $20 ***copay*** Multiple Source Brand Name: 34 day $25 ***copay*** 90 day $50 ***copay***
Limitation: *"Maintenance Drugs (drugs which are prescribed for long-term usage) may be dispensed in a ninety (90) day supply at the pharmacy". All other drugs will allow up to a 34 day supply.*	
Mail Order Option	
Mail Order Prescription	100% after ***copay***
Copay	ACA Required Medications: $0 ***copay*** Generic: $10 ***copay*** Single Source Brand Name: $20 ***copay*** Multiple Source Brand Name: $50 ***copay***
Limitation: 90 day supply	