The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Core Management Recourses at 1-888-741-2673. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Uniform-Glossary-12-19-14-FINAL.pdf or call CORE to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** per person. Does not apply to in-network preventive care. **$3,000** per person out of network.	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 services covered before you meet your deductible?	**Yes.**	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. See your plan document for a list of covered **payment provisions**.
Are there other deductibles for specific services?	**Yes.** Per hospital admission: **$500** at In-network; **$1,000** Out-of-network. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network medical providers **$6,600** person/Family **$13,200**. For out-of-network medical providers **unlimited** person/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, copayments, 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**.
Will you pay less if you use a network provider?	**Yes**. See **www.corehealthbenefits.com or call 1-888-741-2673** for a list of in-network providers.	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. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you 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.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-pay/visit 30% coinsurance	Deductible, 50% coinsurance, Except for OB/GYN: $35 co-pay and 30% coinsurance.	Except for OB/GYN: $35 co-pay and 30% coinsurance. Office visits with a DCH facility or employed physician are payable at 100% per member per Plan Year.
	Specialist visit	$35 co-pay/visit and 30% coinsurance	Deductible, 50% coinsurance, Except for OB/GYN: $35 co-pay and 30% coinsurance.	Except for OB/GYN: $35 co-pay and 30% coinsurance. Offices visits with a DCH facility or employed physician are payable at 100% per member per Plan Year.
	Preventive care/screening/ immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, 30% coinsurance	Deductible, 50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	Deductible, 30% coinsurance	Deductible, 50% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.corehealthbenefits.com	Generic drugs	**Retail**: $10 co-pay **OR** 25% cost of drug/ prescription. **Mail order**: $20 co-pay **OR** 25% cost of drug after $150/prescription.	Not Covered	Copayment is the greater of the flat-dollar copayment or coinsurance. Retail pharmacy – 30-day supply only; Mail order – 60 or 90-day supply.
	Preferred brand drugs	**Retail**: $30 co-pay **OR** 30% cost of drug/ prescription. **Mail order**: $60 co-pay **OR** 30% cost of drug after $150/prescription.	Not Covered	Copayment is the greater of the flat-dollar copayment or coinsurance. Retail pharmacy – 30-day supply only; Mail order – 60 or 90-day supply.
	Non-preferred brand drugs	**Retail**: 30% cost of drug under $150 **OR** 50% cost of drug/ prescription. **Mail order**: 50% cost of drug under $150 **OR** 50% cost of drug $150 and over/prescription.	Not Covered	Copayment is the greater of the flat-dollar copayment or coinsurance. Retail pharmacy – 30-day supply only; Mail order – 60 or 90-day supply.
	Specialty drugs	n/a	Not Covered	see above categories
If you have outpatient	Facility fee (e.g., ambulatory	Deductible and 30%	Deductible and 50%	Pre-certification required, subject to a $1,000

* For more information about limitations and exceptions, see the plan or policy document at www.corehealthbenefits.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
surgery	surgery center)	coinsurance	coinsurance	penalty.
	Physician/surgeon fees	Deductible and 30% coinsurance	Deductible and 50% coinsurance	Pre-certification required, subject to a $1,000 penalty.
If you need immediate medical attention	Emergency room care	$150 copayment per visit deductible then 30% coinsurance	$150 copayment per deductible visit then 30% coinsurance	Copayment is waived if accident, admitted within 24 hours, or true emergency
	Emergency medical transportation	Deductible, Ground Transportation 30% coinsurance and Air Ambulance 40% coinsurance	Deductible, Ground Transportation 30% coinsurance and Air Ambulance 40% coinsurance	——————none——————
	Urgent care	Deductible and 30% coinsurance	Deductible and 50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible and 30% coinsurance	Deductible and 50% coinsurance	Pre-certification required, subject to a $1,000 penalty.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible and 30% coinsurance	Deductible and 50% coinsurance	Pre-certification required, subject to a $1,000 penalty.
	Inpatient services			
If you are pregnant	Office visits	Deductible and 30% coinsurance	Deductible and 30% coinsurance	——————none——————
	Childbirth/delivery professional services	Deductible and 30% coinsurance	Deductible and 30% coinsurance	Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean), subject to a $1,000 penalty.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	Deductible and 30% coinsurance	Deductible and 50% coinsurance	Pre-certification required, subject to a $1,000 penalty. Maximum 120 days per Plan year. Must be reviewed and approved every 30 days
	Rehabilitation services			Pre-certification required, subject to a $1,000 penalty. Limited to Twenty-Five (25) visits.
	Habilitation services			Pre-Notification required, subject to a $1,000 penalty.
	Skilled nursing care			Pre-Notification required, subject to a $1,000 penalty. Maximum 30 visits per Plan year.
	Durable medical equipment			All DME in excess of $500 require preauthorization by CORE, subject to a $1,000

* For more information about limitations and exceptions, see the plan or policy document at www.corehealthbenefits.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				penalty. **(Replacement not covered).**
	Hospice services			Must be reviewed and approved every 60 days
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Vision screening **ONLY** under Medical Plan. $100 calendar year maximum
	Children's glasses	Not Covered	Not Covered	————————none————————
	Children's dental check-up	No Charge	Not Covered	Oral health risk assessment **ONLY** under Medical Plan; see Dental Plan

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any 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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Core at 1-888-741-2673.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-741-2673.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-741-2673.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-741-2673.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-741-2673.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$125
Coinsurance	$3,202
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,327**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$740
Coinsurance	$1,398
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,138**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$320
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

* For more information about limitations and exceptions, see the plan or policy document at www.corehealthbenefits.com