

CORE Management Resources: CORE

Coverage for: All Coverage Levels | Plan Type: PPO

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, [insert contact information]. 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 1-888-741-2673 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$500 person / \$1,500 family. Does not apply to in-network or out-of-network preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. See your plan document for a list of covered <u>payment provisions</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$500 for Out-of-Network Facility per admission deductible.	You must pay all the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For in-network providers \$5,000 person / \$15,000 family. For out-of-network providers \$10,000 person / \$30,000 family.	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	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 <u>provider</u> , 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 <u>provider</u> for some services. See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> 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	\$25 copay/visit and 20% coinsurance	40% coinsurance	_____none_____
	Specialist visit	\$25 copay/visit and 20% coinsurance	40% coinsurance	
	Preventive care / screening /immunization	see limitations	see limitations	Plan pays 100% of eligible expenses up to \$500; eligible expenses exceeding \$500; 20% coinsurance for in-network or 40% coinsurance for out-of-network., after the deductible has been met.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible (if not performed at health care provider's office or clinic)	40% coinsurance after deductible (if not performed at health care provider's office or clinic)	If performed during a visit to a health care provider, see above for benefit. Penalty for failure of preauthorization is \$500/In-network and \$1,000/Out-of-network.
	Imaging (CT/PET scans, MRIs)			
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 20% cost of drug/prescription. Mail order: \$20 co-pay OR 20% cost of drug/prescription.	N/A	Copayment is the greater of the flat-dollar copayment or coinsurance. Retail pharmacy— 30-day supply only; Mail order— 90-day supply.
	Preferred brand drugs	Retail: \$20 co-pay OR 20% cost of drug/prescription. Mail order: \$40 co-pay OR 20% cost of drug/prescription.		
	Non-preferred brand drugs	Retail: \$35 co-pay OR 20% cost of drug/prescription. Mail order: \$70 co-pay OR 20% cost of drug/prescription.		
	Specialty drugs	N/A		N/A

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is \$500/In-network and \$1,000/Out-of-network.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is \$500/In-network and \$1,000/Out-of-network.
If you need immediate medical attention	Emergency room care	\$150 copayment per visit then 20% coinsurance	\$150 copayment per visit then 40% coinsurance	Copayment is waived if an accident, or admitted within 24 hours, or true emergency.
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	_____none_____
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is \$500/In-network and \$1,000/Out-of-network.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	None
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is \$500/In-network and \$1,000/Out-of-network.
If you are pregnant	Office visits	\$25 copay/visit and 20% coinsurance	40% coinsurance	_____none_____
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	Available for Employee and Spouse ONLY . Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean).
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Must be reviewed and approved every 30 days.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required for occupational therapy, pulmonary therapy, pulmonary rehabilitation and speech therapy. Limit 25 visits. Inpatient Rehabilitative Facility (IRF) limit is 15 days.
	Habilitation services			
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Maximum 30 days per calendar year

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)	
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	All DME in excess of \$500 require preauthorization by CORE.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Must be reviewed and approved every 60 days
If your child needs dental or eye care	Children's eye exam	See Limitations	See Limitations	Maximum allowable for Eye Exam is \$100 which is included in the Wellness Benefit of \$500.
	Children's glasses	Not Covered	Not Covered	n/a
	Children's dental check-up	Not Covered	Not Covered	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 | • Hearing aids | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery | • Infertility treatment | • Weight loss programs |
| • Cosmetic surgery | • Long-term care | |

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

- | | | |
|--|--|---------------------|
| • Chiropractic care | | |
| • Dental care (Adult) for accidental injury, removal of tumors, removal of unerupted/impacted teeth, or correction of congenital abnormalities | • Private-duty nursing
Routine eye care (Adult) | • Routine foot care |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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: 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, kwijigo 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	\$500
■ Specialist [<i>cost sharing</i>]	\$25
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

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	\$12800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$275
Coinsurance	\$2405
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3180

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$500
■ Specialist [<i>cost sharing</i>]	\$25
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

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	\$7400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1100
Coinsurance	\$1160
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2760

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$500
■ Specialist [<i>cost sharing</i>]	\$25
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

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	\$1900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$215
Coinsurance	\$237
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$952