



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 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 1-888-741-2673 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<b>Plan E -Bronze- \$3,750</b> person/ <b>\$7,500</b> Family In-Network/ <b>\$7,500</b> person/ <b>\$15,000</b> Family Out-of-Network Doesn't apply to In-Network Routine Annual Exam.	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> ?	<b>Yes.</b> Preventative care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventative services without cost sharing and before you meet your deductible. See a list of covered preventative services at <a href="https://www.healthcare.gov/coverage/preventative-care-benefits/">https://www.healthcare.gov/coverage/preventative-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For In-Network providers <b>\$7,200</b> person / <b>\$14,400</b> annually per family. For Out-of-Network Providers <b>Unlimited person</b>	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, 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. For a list of In-Network providers, see <a href="http://www.corehealthbenefits.com">www.corehealthbenefits.com</a> or call 1-888-741-2673.	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. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$55 Co-pay	50% coinsurance after deductible	_____none_____
	<a href="#">Specialist</a> visit	\$80 Co-pay	50% coinsurance after deductible	_____none_____
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No cost	50% coinsurance after deductible	_____none_____
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	25% coinsurance after deductible	50% coinsurance after deductible	Prior authorization may be required for specific services.
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	50% coinsurance after deductible	Prior authorization may be required for specific services
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.corehealthbenefits.com">www.corehealthbenefits.com</a>	Generic drugs	\$10 co-pay (retail) \$20 copay (mail order)	None	Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Preferred brand drugs	Greater of \$55 co-pay or 25% (\$150 Max) (retail) <b>OR</b> (mail order) greater of \$110 copay or 25% coinsurance (\$300 max)	None	The greater of the flat-dollar co-payment or coinsurance. Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Non-preferred brand drugs	Greater of \$90 co-pay or 50% (max \$350) (retail) <b>OR</b> (mail order) greater of \$180 copay or 50% coinsurance (\$300 max)	None	The greater of the flat-dollar co-payment or coinsurance. Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	<a href="#">Specialty drugs</a>	Generic- 10% (\$100 max) Preferred- 30% (\$1,000 max) Non-Preferred- 50% (\$1,500 max)	None	Retail- 30-day supply Mail Order- N/A
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Physician/surgeon fees			
<b>If you need immediate medical</b>	<a href="#">Emergency room care</a>	Deductible then \$225 Co-pay plus 25% coinsurance	Deductible then \$225 Co-pay plus 25% coinsurance	Non-accident, non-emergency services is not covered. \$225 co-pay plus 25% co-insurance, per admittance, (waived if admitted.)

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)	
<b>attention</b>	<a href="#">Emergency medical transportation</a>	25% coinsurance after deductible	50% coinsurance after deductible	—————none—————
	<a href="#">Urgent care</a>	\$75 co-pay	\$75 co-pay, 50% coinsurance after deductible	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible then \$700 Co-pay plus 25% coinsurance	Deductible then \$1,800 Co-pay plus 50% coinsurance	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Physician/surgeon fees	25% coinsurance after deductible	50% coinsurance after deductible	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	25% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Inpatient services			
<b>If you are pregnant</b>	Office visits	25% coinsurance after deductible	50% coinsurance after deductible	NONE
	Childbirth/delivery professional services	25% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean). 50% reduced benefits/coinsurance for noncompliance.
	Childbirth/delivery facility services			
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	25% coinsurance after deductible	50% coinsurance after deductible	120-day calendar year maximum. Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	<a href="#">Rehabilitation services</a>			25 days per calendar year maximum. Preauthorization required.
	<a href="#">Habilitation services</a>			30 days per calendar year maximum. Preauthorization required.
	<a href="#">Skilled nursing care</a>			
	<a href="#">Durable medical equipment</a>			Preauthorization required for all DME in excess of \$500, penalty for noncompliance
	<a href="#">Hospice services</a>			Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.

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 your child needs dental or eye care	Children's eye exam	\$50 co-pay	\$50 co-pay	One (1) eye exam routine benefit per program year.
	Children's glasses	\$50 co-pay plus cost that exceed plan	\$50 co-pay plus cost that exceed plan	One (1) pair of lenses per program year. One (1) pair of frames every 24 months.
	Children's dental check-up	20% coinsurance	20% coinsurance	One (1) dental exam every six (6) months

#### 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                                       | • Routine eye care     |
| • Bariatric surgery | • Infertility treatment                              | • Routine foot care    |
| • Cosmetic surgery  | • Long-Term care                                     | • Weight loss programs |
| • Dental (Adult)    | • Non-emergency care when traveling outside the U.S. |                        |

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. 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](http://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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,750
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$80
■ Hospital (facility) [ <i>cost sharing</i> ]	25%
■ Other [ <i>cost sharing</i> ]	25%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,540</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,750
Copayments	\$80
Coinsurance	\$928
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,758</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,750
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$80
■ Hospital (facility) [ <i>cost sharing</i> ]	25%
■ Other [ <i>cost sharing</i> ]	25%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,750
Copayments	\$480
Coinsurance	\$234
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$4,464</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,750
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$80
■ Hospital (facility) [ <i>cost sharing</i> ]	25%
■ Other [ <i>cost sharing</i> ]	25%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,450</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,450
Copayments	\$465
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,950</b>