




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> ?	Plan A - GOLD \$1,750 person/\$3,500 Family In-Network/ \$3,500 person/\$7,000 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> ?	Yes. 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. 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 https://www.healthcare.gov/coverage/preventative-care-benefits/ .
Are there other <u>deductibles</u> 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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For In-Network providers \$3,500 person /\$7,000 annually per family. For Out-of-Network Providers Unlimited person	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 www.corehealthbenefits.com 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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 Co-pay	50% coinsurance after deductible	—————None—————
	Specialist visit	\$55 Co-pay	50% coinsurance after deductible	Chiropractic care Coverage is limited to 20 visits maximum. No coverage for Acupuncture.
	Preventive care/ screening/ immunization	No cost	50% coinsurance after deductible	—————None—————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	50% coinsurance after deductible	Prior authorization may be required for specific services.
	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	\$10 co-pay (retail) \$25 copay (mail order)	—————None—————	Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Preferred brand drugs	\$25 co-pay or 25%, whichever is greater. (\$100 Max) (retail) OR (mail order) greater of \$50 copay or 25% coinsurance (Max \$200)		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	\$50 co-pay or 50%, whichever is greater. (\$300 Max) (retail) OR (mail order) greater of \$100 copay or 50% coinsurance (Max \$600).		The greater of the flat-dollar co-payment or coinsurance. Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Specialty drugs	Generic- \$50 Preferred- 20% (\$1,000 Max) Non-Preferred- 50% (\$1,500 Max)		Retail pharmacy- 30-day supply Mail Order- N/A
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	Deductible then \$225 Co-pay plus 20% coinsurance	Deductible then \$200 Co-pay plus 20%	Non-accident, non-emergency services is not covered. \$225 co-pay plus 20% co-insurance,

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)	
			coinsurance	per admittance, (waived if admitted.)
	Emergency medical transportation	20% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Urgent care	\$75 co-pay	\$75 co-pay 50% coinsurance after deductible	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then \$225 Co-pay plus 20% coinsurance	Deductible then \$600 Co-pay plus 50% coinsurance	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Inpatient services			
If you are pregnant	Office visits	20% coinsurance after deductible	50% coinsurance after deductible	NONE
	Childbirth/delivery professional services	20% 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			
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	120-day calendar year maximum. Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Rehabilitation services			25 days per calendar year maximum. Preauthorization required.
	Habilitation services			25 days per calendar year maximum. Preauthorization required.
	Skilled nursing care			30 days per calendar year maximum. Preauthorization required.
	Durable medical equipment			Preauthorization required for all DME in excess of \$500, penalty for noncompliance
	Hospice services			Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
If your child needs	Children's eye exam	\$50 co-pay	\$50 co-pay	One (1) eye exam routine benefit per program

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)	
dental or eye care				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](#).)

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery Dental (Adult) | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-Term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care • 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 |
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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, kwijjigo 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	\$1750
■ Specialist [<i>cost sharing</i>]	\$55
■ 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	\$7540
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1750
Copayments	\$110
Coinsurance	\$1186
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$2996

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1750
■ Specialist [<i>cost sharing</i>]	\$55
■ 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	\$5400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1750
Copayments	\$550
Coinsurance	\$620
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2920

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1750
■ Specialist [<i>cost sharing</i>]	\$55
■ 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	\$2450
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1750
Copayments	\$335
Coinsurance	\$73
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2158