**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 deductible?** | **Plan Levels** are:<br>Gold - $2,000 person/$4,000 family.<br>Silver - $3,500 person/$7,000 family.<br>Bronze - $5,000 person $10,000 family. Does not apply to in-network preventive care. | 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 in plan document 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.** | For specific services, see the chart in plan document for other costs for services this plan covers. |
| **What is the out-of-pocket limit for this plan?** | In-network providers plan levels:<br>**Gold** - $5,500 person/$11,000 family.<br>**Silver** - $6,000 person/$12,000 family.<br>**Bronze** - $6,500 person/$13,000 family.<br>Out-of-network provider- **Unlimited.** | 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, 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 in plan document 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 | 20% coinsurance after deductible | 50% coinsurance after deductible | ————————none———————— |
| | Specialist visit | 20% coinsurance after deductible | 50% coinsurance after deductible | Chiropractic care: Plan pays 50% of eligible expenses with maximum of $20 payable per visit; limit 25 visits per calendar year |
| | Preventive care/screening/ immunization | No charge | 50% coinsurance after deductible | ————————none———————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible when performed at MRMC Facility/Doctor | 50% coinsurance after deductible | 40% coinsurance after deductible when performed by MHP provider |
| | Imaging (CT/PET scans, MRIs) | | | |
| **If you need drugs to treat your illness or condition**<br>**OUT OF POCKET MAXIMUM on PHARMACY**<br>(Combined with Medical)<br><br>More information about **prescription drug coverage** is available at www.corehealthbenefits.com | **Tier One - Generic Brand**<br>Zero Co-Pay for Diabetic, Cholesterol, Statin Prescriptions when filled at the MRMC Pharmacy. | MRMC Pharmacy<br>Prescriptions - $5<br>Retail - $10<br>Mail Order - $20 | Services Not Covered | MRMC pharmacy – 30, 60, or 90-day supply. Retail pharmacy – 30-day supply only; Mail order – 60 or 90-day supply. |
| | **Tier 2 – Formulary Brand No Generic** | MRMC Pharmacy<br>prescriptions-$10 or25%<br>Retail - $20 or 25%<br>Mail Order- $40 **OR** 25% copay/prescription | Services Not Covered | Copayment is the greater of the flat-dollar copayment or coinsurance. MRMC pharmacy – 30, 60, or 90-day supply. Retail pharmacy – 30-day supply only; Mail order 60 or 90-day supply. |
| | **Tier 3- Non-Formulary Brand No Generic** | MRMC Pharmacy<br>Prescriptions-$20 or50%<br>Retail - $30 or 50%<br>Mail Order- $60 **OR** 50% copay/prescription | Services Not Covered | |
| | Specialty drugs | N/A | N/A | see above categories |

| 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) | |
| | **Tier 4 - Brand with a generic equivalent** | If the member or physician chooses a brand name drug when there is a generic available, the member will pay 50% copay up to a maximum copayment of $100. | | |
| | **Tier 5 – Contraceptives** | This plan has a zero copayment for all FDA approved contraceptives. However, if the contraceptive has a generic equivalent, only the generic equivalent will have the zero copayment. | | |
| | **Narrative** | Only generic drugs in these three therapeutic drug classes, when purchased at the MRMC pharmacy, are available without a member copayment. If the brand name drug has no generic equivalent, the brand name copayment will be capped at $25 or $50 (formulary/non-formulary). No brand name Hypertensive or Diabetic drugs are available without a member copayment unless that member's annual individual out-of-pocket maximum has been satisfied for their plan. | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 50% coinsurance after deductible | Penalty for failure of preauthorization is denial of claim |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room care | Deductible per ER $250 then 20% coinsurance after deductible | Deductible per ER $250 then 20% coinsurance after deductible | Deductible is waived if admitted |
| | Emergency medical transportation | 20% coinsurance after deductible | 50% coinsurance after deductible | ————————none———————— |
| | Urgent care | | | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Plan deductibles per admission per admission deductibles plus 20% coinsurance per admission. | $2,000 copayment per admission; 50% coinsurance after deductible | Penalty for failure of preauthorization is denial of claim. See plan document for per admission hospital deductibles. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 50% coinsurance after deductible | Penalty for failure of preauthorization is denial of claim |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance after deductible | 50% coinsurance after deductible | ————————none———————— |
| | Inpatient services | | | Penalty for failure of preauthorization is denial of claim |
| **If you are pregnant** | Office visits | 20% coinsurance after deductible | 50% coinsurance after deductible | ————————none———————— |

| 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) | |
| | 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). |
| | 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 | Must be reviewed and approved every 60 days. Maximum 120 days per calendar year. Penalty for failure of preauthorization is denial of claim |
| | Rehabilitation services | 20% coinsurance after deductible | 50% coinsurance after deductible | Preauthorization required for pulmonary rehabilitation and speech therapy, $200 penalty for noncompliance. Limit 25 visits |
| | Habilitation services | | | |
| | Skilled nursing care | 20% coinsurance after deductible | 50% coinsurance after deductible | Maximum 30 days per calendar year |
| | Durable medical equipment | 20% coinsurance after deductible | 50% coinsurance after deductible | All DME in excess of $500 require preauthorization by CORE. |
| | Hospice services | 20% coinsurance after deductible | 50% coinsurance after deductible | Must be reviewed and approved every 60 days. Penalty for failure of preauthorization is denial of claim |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Service Not Covered | Vision screening **ONLY** under Medical Plan; see Vision Plan |
| | Children's glasses | Not Covered | Service Not Covered | Not Covered under Medical Plan; see Vision Plan |
| | Children's dental check-up | No Charge | Service 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, and
- 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. 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: Core Management Recourses 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 | $2000 |
| Specialist *[cost sharing]* | 20% |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2000 |
| Copayments | $40 |
| Coinsurance | $2152 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4192** |

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

| | |
|---|---|
| The plan's overall deductible | $2000 |
| Specialist *[cost sharing]* | 20% |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2000 |
| Copayments | $340 |
| Coinsurance | $1012 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$3352** |

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

| | |
|---|---|
| The plan's overall deductible | $2000 |
| Specialist *[cost sharing]* | 20% |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 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** | **$2500** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1000 |
| Copayments | $260 |
| Coinsurance | $248 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1508** |

The plan would be responsible for the other costs of these EXAMPLE covered services.