CORE Management Resources: Stephens County Hospital Plan I

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 1/1/24 – 12/31/24

Coverage for: All Coverage Levels | **Plan Type:** POS

NETWORK- (IN): Stephens County Hospital and Physicians/ Health Partners/ PHCS (OUT): When traveling outside of the primary network for business or vacation, the First Health Network is the statewide and nationwide network of preferred providers.

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?	**SCH- $750** ind./**$2,250** Family **In-Network- $1,500** ind./**$4,500** Family **Out-of-Network- $3,000** ind./**$9,000** Family	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.** Outpatient Physician Services & Preventative care (some exclusions apply) at SCH or in-network provider, Home Health, Hospice and Outpatient diagnostic X-ray/Lab done at SCH 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.
Are there other deductibles for specific services?	**Yes**. $300 Hospital Admission, waived at SCH.	You must pay all of the costs for these services up to the specific deductible amount before this Plan begins to pay for services.
What is the out-of-pocket limit for this plan?	**SCH- $3,000** ind./**$9,000** Family **In-Network- $3,750** person/**$11,250** Family **Out-of-Network- 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?	Prescription drug copayments, 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	**Yes –** You will receive the highest	The Primary Network for this Plan is Stephens County Hospital. If a medical service can be

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use a network provider?	benefits by utilizing services at SCH. You can also visit Health Partners at www.healthpartnersnetwork.com or call 1-770-219-6600.	performed at SCH, all covered members (employees, spouses and children) must have these services performed at Stephens County Hospital or the service is NOT COVERED. For hospital services available at Stephen County Hospital but rendered at an in-network Health Partners provider, services will only be considered at the in-network level of benefits if pre-approved by Core Management Resources. The provider network for physician utilization will continue to be Health Partners. You will receive the highest level of benefits when you seek care at Stephens County Hospital or a Stephens County Hospital Physician. Benefits for services received from our facility or physicians will increase from 80% to 90% coinsurance. When traveling outside of the primary network for business or vacation, PHCS is your statewide and nationwide network of preferred 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. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. 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	SCH- 10% after $25 copay/Lab, X-rays-no cost **(including Radiologist charges for imaging)**, surgery- 10%, coinsurance & deductible waived In-Network- 20% after $25 copay /Lab, X-rays & surgery- 20%, coinsurance & deductible waived	50% coinsurance after deductible	————————None————————
	Specialist visit			
Preventive Care Services	Preventive care/screening (Excludes immunizations, Tobacco cessation products & Rx contraceptives. See below.)	No cost	50% coinsurance after deductible	————————None————————
	Immunizations- 18 and under	No cost	50% after deductible	————————None————————
	Immunizations- 19 and over	SCH- No cost SCH Physicians & all others- Not covered	Not covered	————————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)	
	Tobacco Cessation Products	SCH- No cost SCH Physicians & all others- Not covered	Not covered	————————None————————
	Rx Contraceptives	SCH- No cost. Cost sharing may apply to brand-name drugs that have a generic equivalent. SCH Physicians & In-Network providers- No cost, Cost-sharing may apply to brand-name drugs that have a generic equivalent.	Not covered	————————None————————
If you have a test	Diagnostic test (x-ray, blood work)	SCH- No cost In-Network- 20% after deductible	50% coinsurance after deductible	Prior authorization may be required for specific services.
	Imaging (CT/PET scans, MRIs)	SCH- No cost **(including Radiologist charges)** In-Network- 20% after deductible	50% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.corehealthbenefits.com	Generic drugs	$5 copay	*For Prescription Drugs not purchased at the Stephens County Hospital pharmacy – covered at 80% subject to the Benefit Year deductible of $1,500.	Retail pharmacy – 30-day supply. For Prescription Drugs not purchased at the Stephens County Hospital pharmacy – covered at 80% subject to the Benefit Year deductible of $1,500. Submit the itemized receipts to: Core Management Resources at P.O. Box 90 Macon, GA 31202 for processing. Routine/Preventive immunizations for participants 19 and over, tobacco cessation products and Rx contraceptives are covered only when dispensed by the Stephens County Hospital pharmacy.
	Preferred brand drugs	$25 copay		
	Non-preferred brand drugs	$50 copay		
	Specialty drugs	20% for any drug that costs more than $120 per 30-day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	SCH- 10% coinsurance after deductible In-Network- 20% after deductible	50% coinsurance after deductible	Preauthorization required. $150 Penalty Fee and 40% reduction in coinsurance for noncompliance.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$100 Emergency Room Copay, then 10% coinsurance after deductible		————————none————————
	Emergency medical transportation	10% after SCH 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)	
	Urgent care	SCH- 10% after $25 copay/Lab, X-rays-no cost **(including Radiologist charges for imaging)** Surgery- 10%, coinsurance & deductible waived In-Network- 20% after $25 copay /Lab, X-rays & surgery- 20%, coinsurance & deductible waived	50% coinsurance after deductible	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	SCH- 10% coinsurance after deductible In-Network- 20% after deductible	50% coinsurance after deductible	Preauthorization required. $150 Penalty Fee and 40% reduction in coinsurance for noncompliance. $300 additional per admittance deductible (waived if admitted to SCH).
	Physician/surgeon fees	SCH- 10% coinsurance after deductible In-Network- 20% after deductible	50% coinsurance after deductible	Preauthorization required. $150 Penalty Fee and 40% reduction in coinsurance for noncompliance.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	SCH- 10% coinsurance after $25 copay In-Network- 20% after $25 copay	50% coinsurance after deductible	Preauthorization required. Preauthorization required. $150 Penalty Fee and 40% reduction in coinsurance for noncompliance.
	Inpatient services	SCH- 10% coinsurance after deductible In-Network- 20% after deductible		
If you are pregnant	Office visits	SCH- 10% after $25 copay In-Network- 20% after $25 copay	50% coinsurance after deductible	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	SCH- 10% coinsurance after deductible In-Network- 20% after deductible	50% coinsurance after deductible	Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean). $150 Penalty Fee and 40% reduction in coinsurance for noncompliance.
	Childbirth/delivery facility services			

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 need help recovering or have other special health needs	Home health care	No Charge		Maximum of 1 visit per day. Preauthorization required.
	Rehabilitation services	SCH- 10% coinsurance after deductible In-Network- 20% after deductible	50% coinsurance after deductible	Limited to Outpatient Physical Therapy, Speech Therapy and Occupational Therapy. Preauthorization required.
	Habilitation services			Preauthorization required. ABA Therapy limited to up to age six with a maximum benefit of $10,000 per year.
	Skilled nursing care	SCH- 10% coinsurance after deductible In-Network- 20% after deductible	50% coinsurance after deductible	Three (3) days required hospitalization period, Maximum time from Hospital discharge to convalescent admission is 14 days. 30 days per calendar year maximum. Preauthorization required.
	Durable medical equipment	SCH- N/A In-Network- 20% after deductible	50% coinsurance after deductible	Preauthorization required for all DME in excess of $500, penalty for noncompliance
	Hospice services (includes inpatient, outpatient & Family Bereavement Counseling)	No Cost		None
If your child needs dental or eye care	Children's eye exam	No Cost		Limited to vision screening only.
	Children's glasses	Not covered		Not covered under the Medical Plan
	Children's dental check-up	No Cost		Limited to oral health risk assessment.

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 (Adult)
- Hearing aids
- Infertility treatment
- Long-Term care
- Non-emergency care when traveling outside the U.S.
- 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

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, 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	$750
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,045
Copayments	$70
Coinsurance	$1,165
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,045**

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

The plan's overall deductible	$750
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$730
Coinsurance	$111
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,646**

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

The plan's overall deductible	$750
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$75
Coinsurance	$88
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$913**

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