Build Your CoreMed℠ Plan

Plan Design

Unless otherwise noted, all deductibles, maximums and benefit amounts are applied per person and are reset each January 1.

Deductible *Amount you pay toward covered expenses before the plan pays benefits* **Choose any underlined deductible — You'll receive a 24-month rate guarantee with the option to extend it to 36 months!***	$500, $1,000, $1,500, $2,000, **$3,500, $5,000, $10,000, $15,000, or $25,000** *(Family deductible maximum is two times the deductible and is met collectively by two or more persons.)* $2,000 options: Extend your 12-month rate guarantee to 24 or 36 months! **Choose $15,000 or $25,000 — Your deductible won't reset until 1/1/11!***
Benefit Percentage *Percentage of covered expenses the plan pays after the deductible*	100%, 80%, 70% or 50% *(Georgia: 60% instead of 50%)*
Coinsurance *Percentage of covered expenses you pay after the deductible*	0%, 20%, 30% or 50% *(Georgia: 40% instead of 50%)*
Coinsurance Out-Of-Pocket Maximum *After this maximum is met, the plan pays 100% of covered expenses*	$0 to $7,500 depending on coinsurance *(Family coinsurance out-of-pocket maximum is two times the coinsurance out-of-pocket maximum and is met collectively by two or more persons.)*
Office Visit Copay *With this optional benefit, you pay your copay and the plan pays 100% of the remaining cost of an eligible network office visit including examination, consultation, evaluation, development of a treatment plan, immunizations and allergy shots. See page 8 for details.*	$35 copay Copay applies to each of four network office visits per person Additional visits are covered subject to the deductible and coinsurance
Lifetime Benefit Maximum *The total maximum amount the plan pays*	$2 million or $6 million

Outpatient Benefits

Benefits are subject to the selected deductible and coinsurance unless otherwise noted.

Prescription Drugs – Generic	$15 copay (no deductible or coinsurance)
Prescription Drugs – Brand name	$500 deductible / $25 copay + 50% coinsurance *(Family deductible maximum is $1,000 and is met collectively by two or more persons.)*
Preventive Services	*Benefits for preventive services, as for all covered services, are subject to deductible and coinsurance unless otherwise noted.*
Mammograms, Pap tests and PSA screening	Covered – with no special limits – after you have been insured for 6 months*
Other covered preventive services	Up to $500 in benefits – after you have been insured for 6 months* • If selecting the Office Visit Copay, see page 8 for details
Office Visits	Covered • If selecting the Office Visit Copay, see page 8 for details
Diagnostic Imaging and Laboratory Services	Covered
Outpatient Hospital, Surgical Center or Urgent Care Facility	Covered • Outpatient facility fee: $0 or $200 per outpatient surgery
Professional Ground and Air Ambulance	Covered
Emergency Room	Covered • $75 emergency room fee — waived if admitted to the hospital
Health Care Practitioner Services	Covered
TelaDoc™ Medical Services*	Up to three FREE physician consultations by telephone* • Additional consultations are covered subject to deductible and coinsurance* and cost only $35 each • This service is not covered on plans designed with an Office Visit Copay option
Outpatient Physical Medicine	Up to $3,000 in benefits
Home Health Care	Up to 160 hours

Inpatient Benefits

Benefits are subject to the selected deductible and coinsurance unless otherwise noted.

Inpatient Hospital	Covered • Inpatient facility fee: $0, $200 or $750 per day for first three days of each confinement
Inpatient Rehabilitation Facility	Up to 90 days
Subacute Rehabilitation and Skilled Nursing Facilities	Up to 90 days
Transplants	Covered

**Varies by state.*

The amount of benefits depends upon the plan design components selected, and the premium varies with the amount of benefits. Plan design components are not available in all combinations. Out-of-network provisions may apply. See page 8 for details.