



Benefit Guide for California

Benefits CoreGuardSM Plus

Calendar Year Deductible		Your Choices						
Individual	NETWORK:	\$750	\$1,500	\$2,500	\$3,500	\$5,000	\$7,500	\$10,000
	NON-NETWORK:	\$750	\$1,500	\$2,500	\$3,500	\$5,000	\$7,500	\$10,000
Family	NETWORK:	\$1,500	\$3,000	\$5,000	\$7,000	\$10,000	\$15,000	\$20,000
	NON-NETWORK:	\$1,500	\$3,000	\$5,000	\$7,000	\$10,000	\$15,000	\$20,000

Network Coinsurance Options: 50% 50% 50% 50% 50% 50% 0%

Calendar Year Out-of-Pocket Maximum		Add Your Chosen Deductible to the Amount Below ¹						
Individual	NETWORK:	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	\$0
	NON-NETWORK:	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500
Family	NETWORK:	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	\$0
	NON-NETWORK:	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000

How family deductibles and family out-of-pocket maximums work: Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.

Lifetime Maximum: Unlimited

Covered Services Your Share of Costs (after deductible)

Doctors' Office Visits
 NETWORK: 50% Coinsurance (or 0% Coinsurance with \$10,000 plan)
 NON-NETWORK: 70% Coinsurance (or 30% Coinsurance with \$10,000 plan)

Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)
 NETWORK: 50% Coinsurance (or 0% Coinsurance with \$10,000 plan)
 NON-NETWORK: 70% Coinsurance (or 30% Coinsurance with \$10,000 plan)

Inpatient Services (overnight hospital/facility stays)
 NETWORK: 50% Coinsurance PLUS \$500 Facility Copay¹ per day up to the first 3 days (with \$750, \$1,500, \$2,500)
 50% Coinsurance (with \$3,500, \$5,000, \$7,500)
 0% Coinsurance (with \$10,000)
 NON-NETWORK: 70% Coinsurance PLUS \$500 Facility Copay¹ per day up to the first 3 days (with \$750, \$1,500, \$2,500)
 70% Coinsurance (with \$3,500, \$5,000, \$7,500)
 30% Coinsurance (with \$10,000)

Outpatient Services (without overnight hospital/facility stays)
 NETWORK: 50% Coinsurance PLUS \$200 Facility Copay¹ per admission (with \$750, \$1,500, \$2,500)
 50% Coinsurance (with \$3,500, \$5,000, \$7,500)
 0% Coinsurance (with \$10,000)
 NON-NETWORK: 70% Coinsurance PLUS \$200 Facility Copay¹ per admission (with \$750, \$1,500, \$2,500)
 70% Coinsurance (with \$3,500, \$5,000, \$7,500)
 30% Coinsurance (with \$10,000)

Emergency Room Services
 NETWORK: 50% Coinsurance (or 0% Coinsurance with \$10,000 plan)
 NON-NETWORK: 50% Coinsurance (or 0% Coinsurance with \$10,000 plan)

Preventive Care Services
 Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.
 NETWORK: 0% Coinsurance, not subject to deductible
 NON-NETWORK: 70% Coinsurance (or 30% Coinsurance with \$10,000 plan)

Maternity: Not Covered

Optional Coverage (at additional cost): Dental, Life

Prescription Drug Coverage CoreGuard Plus

Retail Drugs (and Mail Order Drugs when available)
 NETWORK:
 Tier 1 (Generic drugs): \$15 Copay
 \$7,500 annual Prescription Drug deductible per member applies before the following:
 - Tier 2 (Formulary Brand name drugs): \$40 Copay
 - Tier 3 (Non-Formulary Brand name drugs): \$60 Copay
 - Specialty: 25% Coinsurance up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to \$750 annual deductible.
 NON-NETWORK: Not Covered

Optional Drug Coverage (when available): Not Available

Other Covered Benefits include but are not limited to: Ambulance, Chiropractic Services, Home Health Care, Mental Health, Physical/Occupational Therapy, Urgent Care

¹ Facility Copay only applies to \$750, \$1,500 and \$2,500 deductible plans. Facility Copay does not accumulate toward the deductible or out-of-pocket maximum. Facility Copay is still required even if out-of-pocket maximum has been met. Balance of covered charges subject to deductible and coinsurance. No additional Facility Copay if readmitted to the same facility within 72 hours of the initial admission.

NOTES: Discounted network rates apply for network covered services. Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other. For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount. Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the Policy.