Major Medical - CoreMed Platinum Plan Features

Major Medical - CoreMed Platinum plans include a variety of deductible levels and flexible options.

- Preventive care recommended under the Affordable Care Act is paid at 100%, before you pay any deductible or coinsurance. [1]
- No annual or lifetime dollar limits on doctor visits, prescriptions, hospitalization, emergency care or outpatient care.
- Access to advocates who can compare cost and quality data and help you understand and make the most of your plan.
- Includes coverage for essential health benefits like emergency, hospitalization, prescriptions, mental health, substance abuse and more.

[1] Immediate coverage paid at 100% for in-network preventive services mandated by the Patient Protection and Affordable Care Act; additional preventive services paid subject to deductible and coinsurance. Varies by state.

INDIVIDUAL OUT-OF-POCKET AMOUNTS					
DEDUCTIBLE		COINSURANCE		TOTAL OUT-OF-POCKET	
Network	Non-network	Network	Non-network	Network	Non-network
$950	$5,000	100%	50%	$950	$10,000

COVERAGE FOR EVERYDAY NEEDS	
Preventive Medicine and Wellness Services	Immediate coverage paid at 100% for in-network preventive services mandated by the Patient Protection and Affordable Care Act (see ahrq.gov/clinic/uspstfix.htm for more information); additional preventive services paid subject to plan deductible and coinsurance.
Doctor's Office Visits	Subject to the plan deductible and coinsurance.
Diagnostic Imaging Services and Laboratory Services	Subject to the plan deductible and coinsurance.
Prescription Drugs	This plan includes average discounts of 30-40% on prescription drugs, subject to the plan deductible and coinsurance. Plan pays 100% after total out-of-pocket maximum has been met.

COVERAGE FOR HOSPITALIZATION AND SURGERY	
Emergency Room Services	$100 access fee (waived if admitted) then covered charges are subject to the plan deductible and coinsurance.
Ambulance Services	Benefits will be provided for professional ground or air transportation in an ambulance for a covered person who needs emergency treatment for a sickness or an injury to the nearest acute medical facility that can treat the sickness or injury. The ambulance service must meet all applicable state licensing requirements. When the due written proof of loss is received, benefits will be paid jointly to the provider of the ambulance care and transportation and to the covered person, unless they have been assigned to the provider. If the provider is a participating provider, the provider will be paid directly for any covered charges. Subject to the plan deductible and coinsurance.
Durable Medical Equipment and Personal Medical Equipment	Subject to the plan deductible and coinsurance.
Habilitative and Rehabilitative Services	Subject to plan deductible and coinsurance. Limited to 30 visits per person per calendar year for Physical Therapy. Subacute rehabilitation facility and/or skilled nursing facility care is limited to 60 days per person per calendar year. Home health care services are limited to 60 visits per person per calendar year.

OTHER COVERAGE AND BENEFITS	
Specialty Pharmaceutical Drugs	Subject to plan deductible and coinsurance. Charges for specialty drugs must be obtained by a designated specialty pharmacy provider as designated by us to be considered at the participating provider level. Specialty drugs obtained from a non-designated provider will not be covered. Benefits will not be paid for any specialty drugs that are not authorized by the Medical Review Manager.
Child Vision Services	Subject to plan deductible and coinsurance for covered persons under 19 years of age. Limited to 1 screening eye exam per covered person per calendar year. Designated Eyewear Provider Benefits: Choice of 1 pair of glasses or an annual supply of contact lenses for eyewear in the Pediatric Eyewear Collection, per calendar year. Charges for eyewear purchased from a Designated Eyewear Provider that is not part of the Pediatric Eyewear Collection are considered as Non-Participating Provider Benefits. Non-Participating Provider Benefits: Choice of: glasses or an annual supply of contact lenses; subject to a Maximum Benefit limitation of $150 per Calendar Year. Medically Necessary contact lenses are subject to a Maximum Benefit limitation of $600, per Calendar Year.
Child Dental Services	Child Dental Services benefits are available only to covered persons under 19 years of age. Limited to 1 check up every 6 months. Not subject to plan deductible. Non-participating provider benefits are limited to $3,000 per person per calendar year. Dental coinsurance applies for covered services for each class of benefits.

WHAT'S NOT COVERED
View Medical Plan Exclusions

$5,000 Accident Medical Expense Coverage, for Primary Only

- AME maximum benefit limitation - $5,000 per accident
- Deductible per accident - $250
- Benefit percentage - 100%
- Treatment-specific limitations:
  - Benefits for air or ground ambulance services - limit of $300 per accident
  - Physical medicine - Maximum benefit of $25 per visit day, up to $250 per accident
  - Durable medical equipment and personal medical equipment - Maximum benefit of $100 per accident

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS	
Accidental Death and Dismemberment maximum benefit limitation	All accidental dismemberment benefits and the accidental death benefits combined are limited to $5,000 per accident, based on the selected benefit level
Accidental Dismemberment Benefit	Initial treatment or evaluation of the accidental dismemberment must be received within the first 7 days after the date the accident occurs

Accidental dismemberment	Benefit amount paid
Loss of one hand	$2,500
Loss of one foot	$2,500
Loss of sight of one eye	$1,250
Loss of hearing in one ear	$1,250
Loss of speech	$2,500

Accidental Death Benefit

Covered person	Benefit amount paid
Policyholder	$5,000

View Plan Exclusions

Dental Basic coverage, for Primary Only

- $75/visit for Preventive Services (cleanings, exams, x-rays, fluoride) - up to two visits per person each policy year
- $25 - $200/service for Basic Services (anesthesia, fillings, extractions) - in the first policy year, payments are 50% of the per-service benefit
- $500 maximum calendar year benefit for basic services

View Plan Exclusions

For Office Use Only:
To Be Covered: Male Applicant Address: SC 29403
Medical Form/Plan ID: 1401/BCMD Plan Type: Platinum (P1) Date: 10/27/2013 Version: 11.7.0 Area: 0.98
Accident Medical Expense Coverage Form/Plan ID: I827/AMEP Benefit Amount: $5,000
Dental Coverage Form/Plan ID: I079/DENT Dental Level: Basic

Rates may vary slightly and are not guaranteed. This quote is not an insurance contract. Only the actual contract provisions will apply.

Supplemental products are separate contracts available at an additional cost. Benefits described on this website are a result of purchasing two or more policies.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.
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