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, visit at www.corebenefitsinc.com or call 260-492-7451. 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 www.corebenefitsinc.com or call 260-492-7451 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,500 person / $3,000 family - Participating providers, $4,500 person / $9,000 family – Non-Participating providers,	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Network Preventive Care Services.	For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. $50 person / $100 family for dental benefits.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3,500 individual / $7,000 family- Participating providers, Unlimited – Non-Participating providers, Prescription Drug – $3,850 individual / $7,700 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Balance billing charges for Non-Network providers and health care this plan doesn't cover.	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.medpartnersonline.com or call 800-258-0974 for a list of network providers.	Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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	60% coinsurance	
	Specialist visit	20% coinsurance	60% coinsurance	
	Preventive care/screening/ immunization	No charge Deductible does not apply	60% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	60% coinsurance	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	60% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by $500.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com	Generic drugs	Retail pharmacy: 20% copayment ($10 minimum) Mail order: $25 copayment (Deductible applies first)	Not covered	RX Out of Pocket Maximum – $3,850 single / $7,700 family
	Preferred brand drugs	Retail pharmacy: 30% copayment ($20 minimum) Mail order: $50 copayment (Deductible applies first)	Not covered	RX Out of Pocket Maximum – $3,850 single / $7,700 family
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	60% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by $500.

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)	
	Physician/surgeon fees	20% coinsurance	60% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by $500.
If you need immediate medical attention	Emergency room care	For medical emergency only: 20% coinsurance Non-emergency medical care 20% coinsurance	For medical emergency only: 60% coinsurance	Life Threatening Emergencies will be covered at the Network level of benefits
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ambulance services are covered if deemed life threatening and/or medically necessary.
	Urgent care	20% coinsurance	60% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	60% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by $500.
	Physician/surgeon fees	20% coinsurance	60% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	60% coinsurance	
	Inpatient services	20% coinsurance	60% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by $500
If you are pregnant	Office Visits	20% coinsurance	60% coinsurance	Coverage for dependents other than spouse excluded.
	Childbirth/delivery professional services	20% coinsurance	60% coinsurance	Coverage for dependents other than spouse excluded.
	Childbirth/delivery facility services	20% coinsurance	60% coinsurance	Coverage for dependents other than spouse excluded.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	60% coinsurance	
	Rehabilitation services	Occupational Therapy: 20% coinsurance OR Speech Therapy: 20% coinsurance OR Physical Therapy: 20% coinsurance	Occupational Therapy: 60% coinsurance OR Speech Therapy: 60% coinsurance OR Physical Therapy: 60% coinsurance	
	Habilitation services			Not covered

* For more information about limitations and exceptions, see the plan or policy document at www.corebenefitsinc.com.

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)	
	Skilled nursing care	20% coinsurance	60% coinsurance	
	Durable medical equipment	20% coinsurance	60% coinsurance	
	Hospice service	20% coinsurance	60% coinsurance	
If your child needs dental or eye care	Children's eye exam			Not Covered
	Children's glasses			Not Covered
	Children's dental check-up	0%	0%	Benefit limited to 2 exam(s) every calendar year $1,000 maximum benefit per year

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
- Cosmetic surgery
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. if travel is for the sole purpose of obtaining medical services
- Routine eye care (Adult)
- Weight loss programs except in cases of morbid obesity

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Dental 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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.

* For more information about limitations and exceptions, see the plan or policy document at www.corebenefitsinc.com.

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: the Plan sponsor at 260-493-7024 or the Plan's Claims processor at 260-492-7451, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/heathreform.

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 Standard? 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.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*----------

* For more information about limitations and exceptions, see the plan or policy document at www.corebenefitsinc.com.

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	$1,500
OB Office Visit	20%
Hospital (facility) coinsurance	20%
Other	

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	$1,500
Copayments	$0
Coinsurance	$2,260
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,760

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other	

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,180
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,680

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other	

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	$1,550

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,510

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