

 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 <u>deductible</u> ?	\$2,500 person / \$5,000 family - Participating <u>providers</u> , \$5,000 person / \$10,000 family – Non-Participating <u>providers</u> ,	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. Network Preventive Care Services.	For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> 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 <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$5,000 individual / \$10,000 family- Participating <u>providers</u> , Unlimited – Non-Participating <u>providers</u> , Prescription Drug – \$2,350 individual / \$4,700 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>Balance billing</u> charges for Non-Network <u>providers</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.medpartneronline.com or call 800-258-0974 for a list of network <u>providers</u> .	Be aware your network <u>provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>).
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copayment</u>	60% <u>coinsurance</u>	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 <u>plan</u> will pay for.
	<u>Specialist</u> visit	\$25 <u>copayment</u>	60% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	60% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by \$500. Deductible is waived if services are rendered through "One Call Medical"
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	60% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.magellanrx.com	Generic drugs	Retail pharmacy: 20% <u>copayment</u> (\$10 minimum) Mail order: \$25 <u>copayment</u> (Deductible applies first)	Not covered	RX Out of Pocket Maximum – \$2,350 single / \$4,700 family
	Preferred brand drugs	Retail pharmacy: 30% <u>copayment</u> (\$20 minimum) Mail order: \$50 <u>copayment</u>	Not covered	RX Out of Pocket Maximum – \$2,350 single / \$4,700 family
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by \$500.

* 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)	
	Physician/surgeon fees	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by \$500.
If you need immediate medical attention	<u>Emergency room care</u>	For medical emergency only: 25% <u>coinsurance</u> after deductible and ER copayment Non-emergency medical care: 25% <u>coinsurance</u> after deductible and ER copayment	For medical emergency only: 60% <u>coinsurance</u> after deductible and ER copayment	Life Threatening Emergencies will be covered at the Network level of benefits
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Ambulance services are covered if deemed life threatening and/or medically necessary.
	<u>Urgent care</u>	\$50 <u>copayment</u>	60% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by \$500.
	Physician/surgeon fees	25% <u>coinsurance</u>	60% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <u>coinsurance</u>	60% <u>coinsurance</u>	
	Inpatient services	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Prior authorization required. Penalties for failure to get prior authorization: benefit payment reduced by \$500
If you are pregnant	Office Visits	\$25 <u>copayment</u>	60% <u>coinsurance</u>	Coverage for dependents other than spouse excluded.
	Childbirth/delivery professional services	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Coverage for dependents other than spouse excluded.
	Childbirth/delivery facility services	25% <u>coinsurance</u>	60% <u>coinsurance</u>	Coverage for dependents other than spouse excluded.
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	
	<u>Rehabilitation services</u>	Occupational Therapy: 25% <u>coinsurance</u> OR Speech Therapy: 25% <u>coinsurance</u> OR Physical Therapy: 25% <u>coinsurance</u>	Occupational Therapy: 60% <u>coinsurance</u> OR Speech Therapy: 60% <u>coinsurance</u> OR Physical Therapy: 60% <u>coinsurance</u>	

* 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)	
	<u>Habilitation services</u>			Not covered
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	60% <u>coinsurance</u>	
	<u>Hospice service</u>	25% coinsurance	60% <u>coinsurance</u>	
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 <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Hearing Aids 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 <u>plan</u> document.)	
<ul style="list-style-type: none"> • Chiropractic care • Dental care 	<ul style="list-style-type: none"> • 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/healthreform.

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.*-----

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** \$2,500
- OB Office Visit \$25
- Hospital (facility) **coinsurance** 25%
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$5,000

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan's** overall **deductible** \$2,500
- **Specialist** **coinsurance** \$25
- Hospital (facility) **coinsurance** 25%
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$75
<u>Coinsurance</u>	\$1,150
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,725

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan's** overall **deductible** \$2,500
- **Specialist** **coinsurance** \$25
- Hospital (facility) **coinsurance** 25%
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,550
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,550