NETWORK- (IN): Liberty Regional Medical Center/ Memorial Health Partners (MHP) (OUT): When traveling outside of the primary network for business or vacation, the First Health Network is your statewide and nationwide network of preferred providers

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, [insert contact information]. 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 https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Uniform-Glossary-12-19-14-FINAL.pdf, or call 1-800-741-2673 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In—Network:** **Individual- $1,000 (LRMC Facility) & $3,000 (MHP)/ Family- $2,000 (LRMC Facility) & $6,000 (MHP)** **Out-of-Network:** **Individual- $6,000/ Family- $12,000** Family Out-of-Network Doesn't apply to In-Network Routine Annual Exam.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventative care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventative services without cost sharing and before you meet your deductible. See a list of covered preventative services at https://www.healthcare.gov/coverage/preventative-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For In-Network providers **$5,500** person /**$11,000 annually** per family. For Out-of-Network Providers **Unlimited/ person**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	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. To search for an In-Network provider, please visit: http://apps.memorialhealth.com/providersearch/findaprovider or call 912-350-6250.	The Primary Network for this Plan is **Liberty Regional Medical Center (LRMC)**. If a medical service can be performed at LRMC, all covered members (employees, spouses and children) must have these services performed at Liberty Regional or the service is NOT COVERED. The provider network for physician utilization is Memorial Health Partners. The provider network for hospital utilization will only include LRMC and Memorial Health Medical Center. The hospitals must be used in that order and you may not proceed to the next hospital when the services you need are available at that hospital. For physician and hospital services not available within your Primary Network, services will only be considered at the in-network level of benefits if pre-approved by Core Management

		Resources Group. **If you do utilize another hospital and the services could have been performed at LRMC, the charges will not be covered at all.** When traveling outside of the primary network for business or vacation, the First Health Network is your statewide and nationwide network of preferred providers. If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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	$35 **OR** $40 Co-pay	50% coinsurance after deductible	————————none————————
	Specialist visit	$45 **OR** $60 Co-pay	50% coinsurance after deductible	Chiropractic care Coverage is limited to 20 visits maximum. No coverage for Acupuncture.
	Preventive care/screening/ immunization	No cost	50% coinsurance after deductible	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	No cost **OR** 25% coinsurance after deductible	50% coinsurance after deductible	Prior authorization may be required for specific services.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.corehealthbenefits.com	Generic drugs	$10 co-pay (retail) **OR** $25 copay (mail order)	None	Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Preferred brand drugs	$30 co-pay (retail) **OR** $50 co-pay **(**mail order)	None	The greater of the flat-dollar co-payment or coinsurance. Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Non-preferred brand drugs	$60 co-pay (retail) **OR** $100 co-pay (mail order)	None	The greater of the flat-dollar co-payment or coinsurance. Retail pharmacy – 30-day supply. Mail order – 60, 90-day supply.
	Specialty drugs	20% ($250 co-pay max.)	None	See above categories.

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)	
		(retail) **OR** 20% ($750 co-pay max per 30-day supply) (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% **OR** 25% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$250 co-pay 20% coinsurance after deductible	$150 co-pay 20% coinsurance after deductible	Non-accident, non-emergency services is not covered. $200 co-pay plus 20% co-insurance, per admittance, (waived if admitted.)
	Emergency medical transportation	25% coinsurance after deductible	50% coinsurance after deductible	————————none————————
	Urgent care	$75 co-pay	$75 co-pay 50% coinsurance after deductible	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 15% coinsurance **OR** Deductible then $400 co-pay plus 25% coinsurance	Deductible then $1,200 Co-pay plus 50% coinsurance	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Physician/surgeon fees	15% **OR** 25% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% **OR** 25% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Inpatient services			
If you are pregnant	Office visits	$35 **OR** $40 Co-pay	50% coinsurance after deductible	————————none————————
	Childbirth/delivery professional services	15% **OR** 25% coinsurance after deductible		Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean). 50% reduced benefits/coinsurance for noncompliance.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	25% coinsurance after deductible	50% coinsurance after deductible	120-day calendar year maximum. Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
	Rehabilitation services			25 days per calendar year maximum.

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)	
	Habilitation services			Preauthorization required.
	Skilled nursing care			30 days per calendar year maximum. Preauthorization required.
	Durable medical equipment			Preauthorization required for all DME in excess of $500, penalty for noncompliance
	Hospice services			Preauthorization required. 50% reduced benefits/coinsurance for noncompliance.
If your child needs dental or eye care	Children's eye exam	$40 co-pay	$50 co-pay	One (1) eye exam routine benefit per program year.
	Children's glasses	$40 co-pay plus cost that exceed plan	$50 co-pay plus cost that exceed plan	One (1) pair of lenses per program year. One (1) pair of frames every 24 months.
	Children's dental check-up	20% coinsurance	20% coinsurance	One (1) dental exam every six (6) months

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
- Bariatric surgery
- Cosmetic surgery
- Dental (Adult)
- Hearing aids
- Infertility treatment
- Long-Term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Chiropractic 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. For more information on your rights to continue coverage, contact the plan at 1-888-741-2673. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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.

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: [insert applicable contact information from instructions].

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 Standards? 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-741-2673.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-741-2673.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-741-2673.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-741-2673.

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	$3000
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	**$12800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3000
Copayments	$400
Coinsurance	$2350
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5750**

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

The plan's overall deductible	$3000
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	**$7400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3000
Copayments	$700
Coinsurance	$925
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4625**

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

The plan's overall deductible	$3000
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	**$3500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$3000
Copayments	$310
Coinsurance	$48
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$3358**

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