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, call Core at 1-888-741-2673. 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.cciio.cms.gov or call 478-275-3150 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250** person/**$750** family Level IA and IB & Level II PPO & Non-PPO	Generally, you must pay all of 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.** Copayments do not apply towards the 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.
Are there other deductibles for specific services?	**Yes**, $50 per person for Prescriptions & $50 per person for Dental services (except Preventive).	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?	**$2,000** person/**$4,000** family Level IA and IB & Level II PPO **Unlimited** person & family Level II Non-PPO	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums; balance-billed charges; charges in excess of UCR (Usual, Customary & Reasonable); any noncompliance penalties; 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**, for Level II Providers. See page 2 for an explanation of Level IA/IB & Level II Providers. To search for an In-Network provider, please visit: https://memorialhealth.com/physicians/ or call 912-350-6250.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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). 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.
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.
Level IA/IB Providers include but are not limited to: Hospitals (Inpatient and Outpatient treatment); Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice); Inpatient and Outpatient Facilities of Mental Disorders, Chemical Dependency, Drug and Substance Abuse; Ambulatory Surgery Centers and Dialysis Clinics
Level II Providers are Physicians and all other Providers of service not defined as a Level IA/IB Provider.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level IA and Level IB Provider	Level II PPO Provider	Level II Non-PPO Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	N/A	$20 copay/visit; 0% coinsurance; deductible waived	40% coinsurance; deductible applies	Family/General Practitioners, Pediatricians, Internists & Obstetricians/Gynecologists are considered Primary Care providers (PCP). PCP copay applies to PPO Mental, Behavioral & Substance Use Disorder Office Visits, Group Therapy, Outpatient Therapy & Office Psychological Testing. There is a $10 copay for Teladoc Telephone Consultations. There is no charge for PPO female sterilization & all PPO FDA approved contraceptive methods. Deductible & 20% coinsurance applies to PPO office surgery & allergy testing. Non-PPO charges are subject to UCR fees.
	Specialist visit	N/A	20% coinsurance; deductible applies	40% coinsurance; deductible applies	
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	Applicable deductible & coinsurance applies to Non-PPO Smoking Cessation. See your plan document for additional benefit information & limitations. Level IA/IB charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

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

If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/visit; 0% coinsurance; deductible waived	No Charge	40% coinsurance; deductible applies	There is no charge for MRIs, CTs & PET Scans billed by KIS Imaging. UR notification required or $500 non-compliance penalty applies. Level IA/IB charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level IA and Level IB Provider	Level II PPO Provider	Level II Non-PPO Provider	
	Imaging (CT/PET scans, MRIs)	$250 copay/day; 0% coinsurance; deductible waived	20% coinsurance; deductible applies	40% coinsurance; deductible applies	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at express-scripts.com	Generic drugs	$50 Prescription deductible then Retail 20% copay/Mail Order 20% copay (minimum $5/maximum $100 Retail & Mail Order)			Covers a 34-day supply for Retail/90-day supply for Mail Order/30-day supply for Specialty. See your plan document for information about drugs that require prior authorization and drugs that are excluded.
	Preferred brand drugs	$50 Prescription deductible then Retail 20% copay /Mail Order 20% copay (minimum $40/maximum $100 Retail & Mail Order)			
	Non-preferred brand drugs				
	Specialty drugs	$50 Prescription deductible then Generic 20% copay/Brand Name 20% copay (Minimum $5/maximum $100 Retail & Mail Order)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit; 0% coinsurance; deductible waived	N/A	N/A	UR notification required or $500 non-compliance penalty applies. Level IA/IB charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
	Physician/surgeon fees	N/A	20% coinsurance; deductible applies	40% coinsurance; deductible applies	
If you need immediate medical attention	Emergency room care	$250 copay/visit; 0% coinsurance; deductible waived	20% coinsurance; deductible applies	20% coinsurance; deductible applies	Treatment of a non-medical emergency is not covered. UR notification required if admitted or $500 non-compliance penalty applies. Level IA/IB charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.

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

	Emergency medical transportation	$250 copay/day; 0% coinsurance; deductible waived	20% coinsurance; deductible applies	20% coinsurance; deductible applies	Non-PPO charges apply to PPO Out-of-Pocket maximum. Level IA/IB charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
	Urgent care	$20 copay/visit; 0% coinsurance; deductible waived	$20 copay/visit; 0% coinsurance; deductible waived	$75 copay/visit; 0% coinsurance; deductible waived	Level IA/IB charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/ confinement; 0% coinsurance; deductible waived	N/A	N/A	UR notification required or $500 non-compliance penalty applies. Level IA/IB charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
	Physician/surgeon fees	N/A	20% coinsurance; deductible applies	40% coinsurance; deductible applies	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level IA and Level IB Provider	Level II PPO Provider	Level II Non-PPO Provider	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$250 copay/day; 0% coinsurance; deductible waived	20% coinsurance; deductible applies	40% coinsurance; deductible applies	See '**If you visit a health care provider's office or clinic**' for the office visit benefit. UR notification required for admissions & day treatment or $500 non-compliance penalty applies. Level IA/IB charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
	Inpatient services	$250 copay/ confinement; 0% coinsurance; deductible waived	20% coinsurance; deductible applies	40% coinsurance; deductible applies	
If you are pregnant	Office visits	N/A	20% coinsurance; deductible applies	40% coinsurance; deductible applies	Office visit copayment applies to the initial visit only. Contact UR for coordination of prenatal care. UR notification required or $500 non-compliance penalty applies. Level IA/IB charges based on Allowable Claims
	Childbirth/delivery professional services				

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

	Childbirth/delivery facility services	$250 copay/ confinement; 0% coinsurance; deductible waived	N/A	N/A	Limits. Non-PPO charges are subject to UCR fees.
If you need help recovering or have other special health needs	Home health care Rehabilitation services Habilitation services Skilled nursing care Durable medical equipment Hospice services	**Inpatient:** $250 copay/ confinement; 0% coinsurance; deductible waived **Outpatient:** $250 copay/day; 0% coinsurance; deductible waived	**Inpatient:** 20% coinsurance; deductible applies **Outpatient:** 20% coinsurance; deductible applies	**Inpatient:** 40% coinsurance; deductible applies **Outpatient:** 40% coinsurance; deductible applies	PPO deductible & coinsurance applies to Level IA/IB Cardiac Rehabilitation, Occupational/Physical/ Speech Therapy & Pulmonary Rehabilitation. Services limited per calendar year to 130 visits for Home Health, 30 visits for Physical Therapy & 60 days for Skilled Nursing Facilities. Hospice limited to $10,000 per lifetime. Treatment of developmental delays may not be covered. See your plan document for additional information. Contact UR for coordination of care for Outpatient Hospice & Home Health. UR notification required for admissions, DME purchases over $500 and all DME rentals or $500 non-compliance penalty applies. Level IA/IB charges based on Allowable Claims Limits. Non-PPO charges are subject to UCR fees.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	No Charge	Benefit applies to routine vision screenings for children. Non-PPO charges are subject to UCR fees.
	Children's glasses	Not Covered			Not Covered
	Children's dental checkup	No Charge			$1,300 dental calendar year maximum applies to age 19+ only. Non-PPO charges are subject to UCR fees.

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.)

- Bariatric Surgery
- Long Term Care
- Routine eye care (Adult)
- Cosmetic Surgery
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Infertility Treatment
- Weight Loss Programs

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

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

- Acupuncture (smoking cessation only)
- Hearing Aids (**only** for initial purchase if hearing loss is due to illness, accidental injury, or surgical procedure)
- Chiropractic Care
- Private Duty Nursing (Inpatient only if hospital has no ICU or ICU is full)
- Dental Care (Adult)

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: 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: 888-741-2673 or the 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:

Español: Para obtener asistencia en Español, llame al 888-741-2673.

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.corehealthbenefits.com.]

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 (deductible, 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**	**$250**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) copayment**	**$250**
■ **Other coinsurance**	**20%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$260
Copayments	$250
Coinsurance	$750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,320**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) copayment**	**$250**
■ **Other coinsurance**	**20%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$910
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,310**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) copayment**	**$250**
■ **Other coinsurance**	**20%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$500
Coinsurance	$230
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$980**

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