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 1-877-848-9997 or visit us at www.mycoresource.com. 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.dol.gov/ebsa/healthreform or www.cciio.cms.gov. or call 1-877-267-2323 x61565 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Tier 1 provider: $500 individual / $1,000 family For Tier 2 provider: $750 individual / $1,500 family For Non-Preferred provider: $900 individual / $1,800 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive 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 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Tier 1 provider: $2,500 individual / $5,000 family For Tier 2 provider: $3,750 individual / $7,500 family For Non-Preferred provider: $6,400 individual / $12,800 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, 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 Eliance providers, PennCare, CHOP, PHC providers, and Aetna providers, see www.mycoresource.com or call 1-877-848-9997.	You pay least if you use a Tier 1 provider in the Eliance Network. You pay more if you use a Tier 2 provider in the PHC or Aetna network (Aetna providers outside the Lancaster county area). You will pay the most if you use a non-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: Tier 1 Provider (You will pay the least)	What You Will Pay: Tier 2 Provider (You will pay the least)	What You Will Pay: Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/office visit	$25 copay/office visit	40% coinsurance	None
	Specialist visit	$30 copay/visit	$35 copay/visit	40% coinsurance	Chiropractic Care and Acupuncture are not covered.
	Preventive care/screening/ immunization	No charge	No charge	40% 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)	No charge	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.expressscripts.com CP = LG Health Convenience Pharmacy or LG Health LifeCare Pharmacy	Generic drugs	CP $6 copay (retail), $15 copay / (mail order) / prescription	$12 copay (retail), $30 copay / (mail order) / prescription	$12 copay (retail) / prescription. Not covered for mail order.	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred brand drugs	CP $25 copay (retail), $62.50 copay / (mail order) / prescription	$40 copay (retail), $100 copay / (mail order) / prescription	$40 copay (retail) / prescription plus cost difference. Not covered for mail order.	
	Non-preferred brand drugs	CP $60 copay (retail), $162.50 copay / (mail order) / prescription	$75 copay (retail), $187.50 copay / (mail order) / prescription	$75 copay (retail) / prescription plus cost difference. Not covered for mail order.	
	Specialty drugs	CP 10% up to $100 maximum / prescription / 30-day supply only. 10% up to a $300 maximum up to 90-day supply	10% up to a $125 maximum / prescription 30-day supply only. 10% up to a $375 maximum / mail order	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay Tier 1 Provider (You will pay the least)	What You Will Pay Tier 2 Provider (You will pay the least)	What You Will Pay Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	Non-emergency use of the Emergency room services will not be covered.
	Emergency medical transportation	10% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	$35 copay/visit	$75 copay/visit	$75 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after $200 copay / admission	20% coinsurance	40% coinsurance	If you don't preauthorize Non-Preferred provider hospitalization, benefits will be reduced by $500.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit	$25 copay/office visit	40% coinsurance	None
	Inpatient services	No charge after $200 copay / admission	20% coinsurance	40% coinsurance	If you don't preauthorize Non-Preferred provider hospitalization, benefits will be reduced by $500.
If you are pregnant	Office visits	No charge initial visit	No charge	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	No charge after $200 copay / admission	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay: Tier 1 Provider (You will pay the least)	What You Will Pay: Tier 2 Provider (You will pay the least)	What You Will Pay: Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	40% coinsurance	None
	Rehabilitation services	10% coinsurance	20% coinsurance	40% coinsurance	No deductible applies at Eliance Provider.
	Habilitation services	Not covered	Not covered	Not covered	No coverage for habilitative services.
	Skilled nursing care	Not applicable	20% coinsurance	40% coinsurance	Limited to 180 day maximum/calendar year. If you don't preauthorize Non-Preferred provider hospitalization, benefits will be reduced by $500.
	Durable medical equipment	10% coinsurance	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	Not applicable	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	No coverage for eye exam.
	Children's glasses	Not covered	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	Not covered	No coverage for dental check-up.

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
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Child / Adult)
- Habilitative Services
- Hearing Aids
- Long Term Care
- Most coverage provided outside the United States. See www.mycoresource.com
- Non-emergency care when traveling outside the U.S.;
- Non-Routine eye care (Child / Adult)
- 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.)

- Bariatric Surgery
- Infertility Treatment (limits apply)
- Private Duty Nursing

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

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272. 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: Department of Labor's 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 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.

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 $500
- Specialist copayment $35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$210
Coinsurance	$160
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$930

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

- The plan's overall deductible $500
- Specialist copayment $35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$690
Coinsurance	$170
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,420

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

- The plan's overall deductible $500
- Specialist copayment $35
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$90
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$750

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

NOTICE OF NON-DISCRIMINATION

Lancaster General Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Lancaster General Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Lancaster General Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters

Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as: Qualified interpreters

Information written in other languages

If you need these services, contact Jennifer Zeiders at 717-544-4578.

If you believe that Lancaster General Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Jennifer Zeiders, Manager – Benefits
555 N Duke Street, PO Box 3555
Lancaster, PA 17604
717-544-4578, Fax 717-544-1351
Or email at jzeiders2@lghealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jennifer Zeiders is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-848-9997.

繁體中文 **(Chinese)**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-848-9997.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-848-9997.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-848-9997.

Deitsch (Pennsylvania Dutch)
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-848-9997.

한국어 **(Korean)**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-848-9997 번으로 전화해 주십시오.

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-848-9997.

(cibarA) ا ل عرب ية
1-877-848-9997 وافر ل ك ب ا ل مجان. ا ت صل ب رق م م لحوظة: إ ذ ا ك نت ت تحدث ا ذك ر ا ل ل غة، ف إ ن خدمات ا ل م ساعدة ا ل ل
غوى ة ت ت

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-848-9997.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-848-9997.
ગુજરાતી (Gujarati)

ચુના: જો તમે □જરાતી બોલતા હો, તો િ ન:□લ્કુ ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો 1-877-848-9997.

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-848-9997.
Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-848-9997.

ខ្មែរ (Cambodian)
ប្រយ័ត□៖ េបើសិន□អ□កនិ□យ □□ែខ□រ, េស□ជំនួយែផ□ក□□ េ□យមិនគិតឈ□□ល គឺ□ច□នសំ□ប់បំេរ□អ□ក។ ចូរ ទូរស័ព□ 1-877-848-9997។

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-848-9997.