

More Information about the Medical Plans

Traditional Medical Plan

The Traditional Medical Plan uses the Anthem Network. You will have one insurance card to use for all services under this plan.

TrueRx is the pharmacy for this Medical Plan for all medications except diabetes medications. All diabetes medications are filled by Northwind Pharmaceuticals.

Specialty drugs are not covered under the plan. Aurora Health is the pharmacy advocacy program to use for specialty medications. To learn more about Aurora Health, visit the Employee Benefits Portal (ascom.mybenefitsinfo.com) or contact Aurora Health at 833-759-6096. After enrollment, register online at <https://www.AuroraHealth.us/register>.

Garner Health is a free benefit that can help reduce your out-of-pocket eligible medical expenses such as co-pays and deductibles when you see a Garner Top Provider. See the Garner Health Benefit section of this Guide.

Blended Medical Plan

The Blended Medical Plan uses both the Anthem Network and Reference Based Pricing.

The Anthem Network coverage is for physician services such as primary care/specialty physician visits and lab work. You will use an Anthem insurance card for these services.

Reference Based Pricing is used for all facility services such as hospital stays, skilled nursing, and advanced imaging services. You will use the card without the Anthem logo for these services. Reference Based Pricing lowers the cost of service by using the Medicare Standard Price as a foundation for the charges.

TrueRx is the pharmacy for this Medical Plan for all medications except diabetes medications. All diabetes medications are filled by Northwind Pharmaceuticals.

Specialty drugs are not covered under the plan. Aurora Health is the pharmacy advocacy program to use for specialty medications. To learn more about Aurora Health, visit the Employee Benefits Portal (ascom.mybenefitsinfo.com) or contact Aurora Health at 833-759-6096. After enrollment, register online at <https://www.AuroraHealth.us/register>.

Garner Health is a free benefit that can help reduce your out-of-pocket eligible medical expenses such as co-pays and deductibles when you see a Garner Top Provider. See the Garner Health Benefit section of this Guide.

For more information about both plans, please call the Enrollment Call Center at 855-288-1607.

What you Need to Know about Using the Traditional Plan and the Blended Plan

1. Call the number on the back of your ID card, 855-258-6467, for any questions you have about how the medical plan works, what's covered and which ID card to use.
2. If you enroll in the Traditional Plan, you use the ID card with the Anthem logo for all services, doctors, hospitals, labs, and imaging.
3. If you enroll in the Blended Plan:
 - a. Use the Physician & Ancillary Services Card with the Anthem logo anytime you see a physician or go to a laboratory.
 - b. Use the AmeriBen card **without** the Anthem logo for hospitals and imaging services.
 - c. Never pay more than your Explanation of Benefits (EOB) says you owe for a medical visit or service.
 - d. Be sure to open all mail you receive from your providers or hospitals and make sure the amount they are billing you is the same as on your Explanation of Benefits (EOB), if it isn't, call the number on the back of your ID card and tell them you may have received a balance bill. AmeriBen will confirm if that is the case or not. If it is a balance bill, AmeriBen will transfer you to Imagine360 and they will explain what steps they are going to take to help you resolve it.
 - e. Read all documents before you sign them and make sure you do not sign/agree to any kind of payment arrangement for a medical bill or service.
 - f. Provider Access Team, Spring Tide Health, may reach out to you in the event a concern by a provider has been encountered.
4. If you live in Fort Wayne, Indiana, and Parkview Hospital is important to you for any facility service other than emergency services, you should consider enrolling in the Traditional Plan.
5. If you live in Richmond, Indiana, and Reid Health is important to you for any facility services other than emergency services, you should consider enrolling in the Traditional Plan.
6. If you encounter a concern, by a provider, hospital, lab, or imaging, please have them call the number on the back of your ID card: 855-258-6467.

Definitions of Important Benefit Terminology

Ancillary Services: Supportive or diagnostic measures that supplement and support a primary physician, nurse, or other healthcare provider in treating a patient. Some examples include diagnostic testing, imaging tests, physical therapy, and laboratory services.

Balance Billing: Occurs when providers bill a patient for the difference between the amount they charge and the amount that the patient's insurance approves. If you receive a bill from a provider/facility for a different amount owed from what your Explanation of Benefits states that you owe, contact AmeriBen immediately at: 855-258-6467.

Co-Insurance: Co-insurance is both you and the Plan sharing a percentage of the expense. Co-insurance applies once you meet your deductible; then you and the Plan each pay a percentage of the remaining cost.

Co-Pay: Co-pay is a flat dollar amount you pay for certain medical services. The Medical and Vision Plans have co-pays.

Deductible: The dollar amount you are responsible for paying before the Plan will pay anything. Deductibles apply to both Medical Plans and to the Dental Plan as well. For services that don't use co-pays, you must meet your deductible before the plan begins to pay its share of the bill. Compare deductibles in each plan.

Eligible Dependents: You may cover certain family members under the benefit plans. These are your eligible dependents for medical, dental, and vision: 1) Your legal spouse. Medical Plan coverage (only) is not available to your spouse if your spouse works and is eligible for medical coverage at his/her job. 2) Your children – your children may include biological children, adopted children, stepchildren, and children for whom you have legal guardianship. Children may be covered up until the end of the month they reach age 26 unless they continue to be an IRS eligible dependent due to a disability. "Eligible Dependents" may differ under the voluntary, supplemental benefits through Lincoln Financial Group. Check with the Enrollment Call Center for more information. Tell the Enrollment Call Center if your dependents live at a different address than you.

Employee Premium: Insurance companies charge a monthly premium for each covered employee. The cost depends on which plan and what level of coverage (single, employee-plus-child, family) the employee chooses. The Company pays a large percentage of the monthly premium, but employees are responsible for paying part of the premium with paycheck deductions. The employee's premium amount is divided evenly among the twenty-six pays each year. **Employees are responsible for paying any missed premium amounts.**

Explanation of Benefits: An explanation of benefits (EOB) is an insurance company's statement that describes the costs involved for visits to your doctor or clinic. The EOB lets you know a claim has been filed, along with details of the costs. An EOB is not a bill.

Facility Services: Costs related to receiving care in a hospital or healthcare facility. Examples are hospital and facility charges and advanced imaging services.

Flexible Spending Accounts: A Flexible Spending Account (FSA) lets you save pre-tax money for certain Health Care and/or Dependent Care expenses. An FSA allows you to save money to pay for expenses that aren't eligible for payment under any other benefit plan. You must re-enroll in FSAs every year; flex account balances do not roll over to a new calendar year.

Out-of-Pocket: The amount you pay during the year for medical expenses. It includes your co-pays, deductibles, and co-insurance amounts.

Preventative Services: Care that keeps you healthy and catches problems early. Examples are annual physicals, screenings, vaccines, and well-child visits.

Professional Service: Care provided by doctors and other healthcare professionals. Examples are office visits with family physicians, internists, pediatricians, or general practitioners.

Reference Based Pricing: A reimbursement method that uses Medicare reimbursement rates (or a derived equivalent) as a reference and prices claims based on a multiple of that rate.

Specialty Care: Care from doctors who focus on a specific area of medicine. Examples are cardiology, dermatology, and orthopedics.

Summary Plan Description: Summary Plan Descriptions (SPD's) contain more detailed information about the plans.

Summary of Benefits and Coverage: The Summary of Benefits and Coverage (SBC) follows the federal guidelines for comparing the Company's two medical plans under similar claim situations, to help you decide which plan is best for you. The comparisons are not cost estimators. SBCs are included in this Guide.