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, contact your Unified Claims Account Manager at 1-800-291-5837. 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 your Human Resources Department at Wabash County Government at 1-260-563-0661 x 1290 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Single / Family $750 / $1,500 EPO Facilities & PPO Providers $1,750 / $2,500 PPO Facilities $3,750 / $4,500 Out-of-Network	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, physician office visits, urgent care, emergency room services, and prescription drugs 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?	Single / Family $3,000 / $6,000 EPO Facilities & PPO Providers $6,000 / $9,000 PPO Facilities Unlimited Out-of-Network **Includes Deductible**	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, balanced billed charges, services this plan doesn't cover and preauthorization penalties.	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 a list of **preferred providers in your network**, see www.parkviewtotalhealth.com or call 1-800-666-4449.	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		EPO Facilities & PPO Providers	PPO Facilities	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit (No Deductible)	**Not Available**	Deductible, 50%	Copay includes the office visit charge only. All other services are subject to deductible/ coinsurance.
	Specialist visit	$50/visit (No Deductible)	**Not Available**	Deductible, 50%	Copay includes the office visit charge only. All other services are subject to deductible/ coinsurance.
	Preventive care/screening/ immunization	No Charge	No Charge	Deductible, 50%	As required by the Affordable Care Act. Deductible and coinsurance do not apply at Tiers 1 & 2.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, 20%	Deductible, 30%	Deductible, 50%	There is no charge for labs obtained at an In-Network independent facility.
	Imaging (CT/PET scans, MRIs)	Deductible, 20%	Deductible, 30%	Deductible, 50%	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	Retail - $10 Copay Mail Order - $20 Copay		Retail- 50% (No Deductible)	Retail 30-90 day supply Mail Order (In-Network only) 90-day supply
	Preferred brand drugs	Retail - $35 Copay Mail Order - $70 Copay		Retail- 50% (No Deductible)	A 90-day supply is available through a retail pharmacy at 3 times the 30-day supply copayment.
	Non-preferred brand drugs	Retail - $70 Copay Mail Order - $210 Copay		Retail- 50% (No Deductible)	There is no charge for certain diabetic and asthmatic supplies. See your pharmacy benefit manager for further details.
	Specialty drugs	25% Copay up to $300		Retail- 50% (No Deductible)	Some specialty drugs may be covered under the medical portion of this plan.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		EPO Facilities & PPO Providers	PPO Facilities	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, 20%	Deductible, 30%	Deductible, 50%	None
	Physician/surgeon fees	Deductible, 20%	**Not Available**	Deductible, 50%	None
If you need immediate medical attention	Emergency room care	$250/visit, then 20%			Copay waived if admitted. Non-emergency treatment in the emergency room is not covered.
	Emergency medical transportation	EPO Deductible, 20%			None
	Urgent care	$50/visit (No Deductible)			Copay includes the office visit charge only. All other services are subject to deductible/ coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, 20%	Deductible, 30%	Deductible, 50%	Precertification required; failure will result in a $250 reduction in benefits.
	Physician/surgeon fees	Deductible, 20%	**Not Available**	Deductible, 50%	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/visit (No Deductible)	**Not Available**	Deductible, 50%	Copay includes the office visit charge only. All other services are subject to deductible/ coinsurance.
	Inpatient services	Deductible, 20%	Deductible, 30%	Deductible, 50%	Precertification required; failure will result in a $250 reduction in benefits.
If you are pregnant	Office visits	Same as any other Illness or as required by the Affordable Care Act.			Coverage for all covered females.
	Childbirth/delivery professional services				
	Childbirth/delivery facility services				

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		EPO Facilities & PPO Providers	PPO Facilities	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	Deductible, 20%	Deductible, 30%	Deductible, 50%	Limited to 120 visits per calendar year. Visit limits do not apply to home infusions or home dialysis.
	Rehabilitation services	Deductible, 20%	Deductible, 30%	Deductible, 50%	Inpatient rehabilitation is limited to 150 days per calendar year combined with skilled nursing and requires precertification; failure will result in a $250 reduction in benefits. Physical and occupational therapies performed in office are subject to a $50 copay and are limited to 40 visits combined per calendar year. Speech therapy is limited to 20 visits per calendar year.
	Habilitation services	Deductible, 20%	Deductible, 30%	Deductible, 50%	
	Skilled nursing care	Deductible, 20%	Deductible, 30%	Deductible, 50%	Precertification required; failure will result in a $250 reduction in benefits. Limited to 150 days per calendar year combined with inpatient rehabilitation.
	Durable medical equipment	Deductible, 20%	Deductible, 30%	Deductible, 50%	None
	Hospice services	No Charge	Deductible, 30%	Deductible, 50%	With six (6) month life expectancy.
If your child needs dental or eye care	Children's eye exam	No Charge		Deductible, 50%	Limited to visual acuity prevention by a Primary Care Physician for children through age 5.
	Children's glasses	Not Covered			None
	Children's dental check-up	No Charge		Deductible, 50%	Limited to dental caries prevention by a Primary Care Physician for preschool age children.

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 (except as specifically stated in the plan document)	• Dental care (adult) • Hearing aids • Infertility treatment	• Long-term care • Routine eye care (adult) • 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 (limited to 12 visits per calendar year)	• Non-emergency care when traveling outside the U.S. (Unless the covered person traveled to that location to receive services, supplies and/or treatment.)	• Private-duty nursing • Routine foot care (Only when medically necessary for the treatment of a metabolic or peripheral vascular disease.)

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: your Human Resources Department at Wabash County Government at 1-260-563-0661 x 1290 , 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 on how 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: Unified Group Services Appeal Department at 1-800-291-5837.

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:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-291-5837]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-5837]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-291-5837]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-291-5837]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

* For more information about limitations and exceptions, see the plan or policy document at www.UnifiedGrp.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 (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	**$750**
Specialist *copayment*	**$50**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**0%**

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	$750
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,480**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$750**
Specialist *copayment*	**$50**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**0%**

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	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

Mia's Simple Fracture

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

The plan's overall deductible	**$750**
Specialist *copayment*	**$50**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**0%**

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	$750
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,450**

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