




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](http://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:
<b>What is the overall <a href="#">deductible</a>?</b>	Single \$750  \$1,750 \$3,750	Family \$1,500 \$2,500 \$4,500 EPO Facilities & PPO Providers PPO Facilities Out-of-Network	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , physician office visits, urgent care, emergency room services, and prescription drugs are covered before you meet your <a href="#">deductible</a> .		This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.		You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Single \$3,000  \$6,000 Unlimited <b>Includes Deductible</b>	Family \$6,000 \$9,000 Out-of-Network EPO Facilities & PPO Providers PPO Facilities Out-of-Network	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their <a href="#">own out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket</a> limit has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	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 <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of <a href="#">preferred providers in your network</a> , see <a href="http://www.parkviewtotalhealth.com">www.parkviewtotalhealth.com</a> or call 1-800-666-4449.		This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No		You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30/visit (No Deductible)	<b>Not Available</b>	Deductible, 50%	Copay includes the office visit charge only. All other services are subject to deductible/ coinsurance.
	<a href="#">Specialist</a> visit	\$50/visit (No Deductible)	<b>Not Available</b>	Deductible, 50%	Copay includes the office visit charge only. All other services are subject to deductible/ coinsurance.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	Deductible, 50%	As required by the Affordable Care Act. Deductible and coinsurance do not apply at Tiers 1 & 2.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (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
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> .	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.
	<a href="#">Specialty drugs</a>	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%	<b>Not Available</b>	Deductible, 50%	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250/visit, then 20%			Copay waived if admitted. Non-emergency treatment in the emergency room is not covered.
	<a href="#">Emergency medical transportation</a>	EPO Deductible, 20%			None
	<a href="#">Urgent care</a>	\$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%	<b>Not Available</b>	Deductible, 50%	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30/visit (No Deductible)	<b>Not Available</b>	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				

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.UnifiedGrp.com](http://www.UnifiedGrp.com)

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	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible, 20%	Deductible, 30%	Deductible, 50%	Limited to 120 visits per calendar year. Visit limits do not apply to home infusions or home dialysis.
	<a href="#">Rehabilitation services</a>	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.
	<a href="#">Habilitation services</a>	Deductible, 20%	Deductible, 30%	Deductible, 50%	
	<a href="#">Skilled nursing care</a>	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.
	<a href="#">Durable medical equipment</a>	Deductible, 20%	Deductible, 30%	Deductible, 50%	None
	<a href="#">Hospice services</a>	No Charge	Deductible, 30%	Deductible, 50%	With six (6) month life expectancy.
<b>If your child needs dental or eye care</b>	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](http://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](http://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](http://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, kwijigo holne' 1-800-291-5837]

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*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](#) \$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$2,480</b>

### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,000</b>

### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,450</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.