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,https://portal.employeeplansllc.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 https://www.healthcare.gov/sbc-glossary or call 1-800-964-7444 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Exclusive Provider, EPO, (Tier 1)** **Individual $ 500 / Family $1,500** **Preferred Provider, PPO, (Tier 2)** **Individual $1,500/ Family $4,500** *** EPO and PPO deductible accrue to each other.** **Non-Preferred providers, Non-PPO, (Does not accrue to any other deductible.)** **Individual $3,500/ Family $10,500**	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 Specialty Lab**	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?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**EPO** **Individual $2,000/ Family $6,000** **PPO** **Individual $5,000/ Family $12,900** *** EPO and PPO accrue to each other.** **Non-Preferred - No limit.**	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?	**Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan does not 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, See www.ParkviewTotalHealth.com or call (800) 666-4449 for a list of network providers.**	This plan uses a provider network. You pay the least if you use a provider in EPO. You pay more if you use a provider in PPO. 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 a non-preferred 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 Exclusive (You will pay the least)	PPO Preferred (You will pay less)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Professional fees 20% coinsurance Facility fees 40% coinsurance	60% coinsurance	Office visit/ Urgent care includes: Diagnostic testing (except MRI, CT & PET scans), injections, allergy testing, allergy serum, allergy injections, and surgery.
	Specialist visit				
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	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. See Section 5, Number 25, in your plan document.
If you have a test	Diagnostic test (x-ray, blood work)	Specialty Lab – No charge Non- Specialty Lab – 20% coinsurance	Specialty Lab – No charge Non-Specialty Lab – 40% coinsurance	60% coinsurance	Specialty Lab - Services performed through DeKalb Memorial Hospital d/b/a DeKalb Health or Lab Corp.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		EPO Exclusive (You will pay the least)	PPO Preferred (You will pay less)	Non-Preferred Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Professional fees 20% coinsurance Facility fees 40% coinsurance	60% coinsurance	---------- None ----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 copay per prescription retail $20 copay per prescription mail order		Not covered	Limited to: 34 day supply retail 90 day supply mail order Retail - Maintenance refills limited to 3 refills. The refill is subject to copays of $20 generic, $60 brand and $90 Brand Non-formulary. Retail and Mail Order - Mandatory generic substitution. If Brand requested when generic is available, member is responsible for the difference in cost, plus the brand copay.
	Preferred brand drugs	$30 copay per prescription retail $60 copay per prescription mail order		Not covered	
	Non-preferred brand drugs	$45 copay per prescription retail $90 copay per prescription mail order		Not covered	
	Specialty drugs	$45 copay per prescription retail $90 copay per prescription mail order		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	60% coinsurance	---------- None ----------
	Physician/surgeon fees	20% coinsurance	20% coinsurance	60% coinsurance	---------- None ----------
If you need immediate medical attention	Emergency room care	20% coinsurance	Professional fees - 20% coinsurance Facility Fees – 40% coinsurance	60% coinsurance	---------- None ----------
	Emergency medical transportation	20% coinsurance	20% coinsurance	60% coinsurance	Must be medically necessary.
	Urgent care	20% coinsurance	20% coinsurance	60% coinsurance	Urgent care includes: Diagnostic testing (except MRI, CT & PET scans), injections, allergy testing, allergy serum, allergy injections, and surgery.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		EPO Exclusive (You will pay the least)	PPO Preferred (You will pay less)	Non-Preferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	60% coinsurance	Penalties of $250.00 for failure to obtain pre-authorization for services
	Physician/surgeon fees	20% coinsurance	20% coinsurance	60% coinsurance`	---------- None ----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Professional fees 20% coinsurance Facility fees 40% coinsurance	60% coinsurance	Office visit includes: Diagnostic testing (except MRI, CT & PET scans), injections, allergy testing, allergy serum, allergy injections, and surgery.
	Inpatient services	20% coinsurance	40% coinsurance	60% coinsurance	Penalties of $250.00 for failure to obtain pre-authorization for services
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	60% coinsurance	Dependent child maternity is not covered. Charges for Office visits are considered under the global delivery fee. Depending on the type of services, a [copayment, coinsurance, or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	60% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	60% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Professional fees – 20% coinsurance Facility fees – 40% coinsurance	60% coinsurance	Limited to 60 professional visits per calendar year.
	Rehabilitation services	20% coinsurance	20% coinsurance	60% coinsurance	Speech therapy must be due to loss or impairment due to illness or injury, other than a functional disorder.
	Habilitation services	20% coinsurance	20% coinsurance	60% coinsurance	Limitations may apply based on the type of service rendered. Refer to your plan document.
	Skilled nursing care	20% coinsurance	Professional fees – 20% coinsurance Facility Fees – 40% coinsurance	60% coinsurance	Limited to 60 professional visits per calendar year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		EPO Exclusive (You will pay the least)	PPO Preferred (You will pay less)	Non-Preferred Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	20% coinsurance	60% coinsurance	---------- None ----------
	Hospice services	20% coinsurance	Professional fees 20% coinsurance Facility fees 40% coinsurance	60% coinsurance	---------- None ----------
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	---------- None ----------
	Children's glasses	Not Covered	Not Covered	Not Covered	---------- None ----------
	Children's dental check-up	Not Covered	Not Covered	Not Covered	---------- None ----------

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
- Dental Care (Adult)
- Experimental/ Investigational Services
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Comfort Items
- Routine Eye care (Adult)
- Routine Foot Care
- Sex transformations or sexual dysfunctions

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

- Chiropractic care (Limited to 20 visits per calendar year)
- Private Duty Nursing
- Weight Loss Programs-individual's weight must be in excess of 170% of standard weight tables

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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,Indiana Department of Insurance, Consumer Service Department, 311 West Washington Street, Suite 300, Indianapolis IN 46204-2787, or go to http://www.in.gov/idoi/2547.htm#2.

* For more information about limitations and exceptions, see the plan or policy document at https://portal.employeeplansllc.com or call 1-800-964-7444

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 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.

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 *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$300
The total Peg would pay is	**$2,400**

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 *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$70
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1630**

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

The plan's overall deductible	$500
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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