

 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:
<p>What is the overall deductible?</p>	<p>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.</p> <p>Non-Preferred providers, Non-PPO, (Does not accrue to any other deductible.) Individual \$3,500/ Family \$10,500</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes- Preventive Care and Specialty Lab</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.</p>
<p>Are there other deductibles for specific services?</p>	<p>No</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>EPO Individual \$2,000/ Family \$6,000 PPO Individual \$5,000/ Family \$12,900 * EPO and PPO accrue to each other.</p> <p>Non-Preferred - No limit.</p>	<p>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.</p>

What is not included in the <u>out-of-pocket limit</u> ?	Penalties for failure to obtain pre-authorization for services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Will you pay less if you use a <u>network provider</u> ?	Yes, See www.ParkviewTotalHealth.com or call (800) 666-4449 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay the least if you use a <u>provider</u> in EPO. You pay more if you use a <u>provider</u> in PPO. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>) Be aware your <u>network provider</u> might use a <u>non-preferred provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	Professional fees 20% <u>coinsurance</u>	60% <u>coinsurance</u>	Office visit/ Urgent care includes: <u>Diagnostic testing</u> (except MRI, CT & PET scans), injections, allergy testing, allergy serum, allergy injections, and surgery. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. See Section 5, Number 25, in your <u>plan</u> document.
	<u>Specialist</u> visit		Facility fees 40% <u>coinsurance</u>		
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	No Charge	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Specialty Lab – No charge	Specialty Lab – No charge	60% <u>coinsurance</u>	Specialty Lab - Services performed through DeKalb Memorial Hospital d/b/a DeKalb Health or Lab Corp.
		Non-Specialty Lab – 20% <u>coinsurance</u>	Non-Specialty Lab – 40% <u>coinsurance</u>		

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% <u>coinsurance</u>	Professional fees 20% <u>coinsurance</u> Facility fees 40% <u>coinsurance</u>	60% <u>coinsurance</u>	----- 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 <u>copay</u> per <u>prescription</u> retail \$20 <u>copay</u> per <u>prescription</u> 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 <u>copays</u> 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 <u>copay</u> .
	Preferred brand drugs	\$30 <u>copay</u> per <u>prescription</u> retail \$60 <u>copay</u> per <u>prescription</u> mail order		Not covered	
	Non-preferred brand drugs	\$45 <u>copay</u> per <u>prescription</u> retail \$90 <u>copay</u> per <u>prescription</u> mail order		Not covered	
	Specialty drugs	\$45 <u>copay</u> per <u>prescription</u> retail \$90 <u>copay</u> per <u>prescription</u> mail order		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60% <u>coinsurance</u>	----- None -----
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	----- None -----
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	Professional fees - 20% <u>coinsurance</u> Facility Fees – 40% <u>coinsurance</u>	60% <u>coinsurance</u>	----- None -----
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	Must be <u>medically necessary</u> .
	Urgent care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	<u>Urgent care</u> includes: <u>Diagnostic testing</u> (except MRI, CT & PET scans), injections, allergy testing, allergy serum, allergy injections, and surgery.

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

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% <u>coinsurance</u>	40% <u>coinsurance</u>	60% <u>coinsurance</u>	Penalties of \$250.00 for failure to obtain <u>pre-authorization</u> for services
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	----- None -----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Professional fees 20% <u>coinsurance</u> Facility fees 40% <u>coinsurance</u>	60% <u>coinsurance</u>	Office visit includes: <u>Diagnostic testing</u> (except MRI, CT & PET scans), injections, allergy testing, allergy serum, allergy injections, and surgery.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60% <u>coinsurance</u>	Penalties of \$250.00 for failure to obtain <u>pre-authorization</u> for services
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	Dependent child maternity is not covered. Charges for Office visits are considered under the global delivery fee. Depending on the type of services, a [<u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u>] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	Professional fees – 20% <u>coinsurance</u> Facility fees – 40% <u>coinsurance</u>	60% <u>coinsurance</u>	Limited to 60 professional visits per calendar year.
	Rehabilitation services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	Speech therapy must be due to loss or impairment due to illness or injury, other than a functional disorder.
	Habilitation services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	Limitations may apply based on the type of service rendered. Refer to your <u>plan</u> document.
	Skilled nursing care	20% <u>coinsurance</u>	Professional fees – 20% <u>coinsurance</u> Facility Fees – 40% <u>coinsurance</u>	60% <u>coinsurance</u>	Limited to 60 professional visits per calendar year.

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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% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	----- None -----
	Hospice services	20% <u>coinsurance</u>	Professional fees 20% <u>coinsurance</u> Facility fees 40% <u>coinsurance</u>	60% <u>coinsurance</u>	----- None -----
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60% <u>coinsurance</u>	----- None -----
	Children's glasses	Not Covered	Not Covered	Not Covered	----- None -----
	Children's dental check-up	Not Covered	Not Covered	Not Covered	----- None -----

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

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>.

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$1,600
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$70
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

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