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 1-765-608-6680. 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 Stephanie Ford, Human Resources Department at Zionsville Community Schools at 1-317-873-2858 extension 11330 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Single / Family $2,400 / $4,800 Ascension St. Vincent Employer Direct Network $6,000 / $12,000 Out-of-Network **This Plan has a Calendar Year Deductible that begins on January 1st.**	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, is 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 $3,400 / $6,800 Ascension St. Vincent Employer Direct Network $8,500 / $17,000 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 the plan, the overall family out-of-pocket must be 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**, see Ascension St. Vincent Employer Direct Network at https://www.advantusnetwork.com/providers-search/ or www.UnifiedGrp.com or call 1-800-291-5837.	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
		Network Provider (You will pay the least)	Out-of-Network 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	After Deductible, $25 Copay	After Deductible, 50%	Copay includes the office visit charge only. All other services will be subject to deductible/coinsurance.
	Specialist visit	After Deductible, $50 Copay	After Deductible, 50%	Copay includes the office visit charge only. All other services will be subject to deductible/coinsurance.
	Preventive care/screening/ immunization	No Charge	Not Covered	As required by the Affordable Care Act. Deductible and coinsurance do not apply. Charges rendered by in-network labs will be paid at 100%, regardless if prescribing provider is out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	After Deductible, 20%	After Deductible, 50%	There is no charge after deductible, for diagnostic laboratory services when St. Vincent's, MACL, Ameripath, and ZCS Wellness Center facilities are utilized.
	Imaging (CT/PET scans, MRIs)	After Deductible, 20%	After Deductible, 50%	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truerx.com	Generic drugs	Pharmacy and Mail Order- After Deductible, $10		Available in pharmacy (30-90 day supply) or Mail Order (90 day supply). Copayment will never be more than the actual drug cost. For Specialty Drugs please see OptiMed for information regarding their mandatory drug program.
	Preferred brand drugs	Pharmacy and Mail Order- After Deductible, $50		
	Non-preferred brand drugs			
	Specialty drugs	After Deductible, 30% Copay		Some specialty drugs may be covered under the medical portion of this plan. Please see your plan document for details.

* For more information about limitations and exceptions, see the plan or policy document at www.UnifiedGrp.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After Deductible, 20%	After Deductible, 50%	None
	Physician/surgeon fees	After Deductible, 20%	After Deductible, 50%	None
If you need immediate medical attention	Emergency room care	After In-Network Deductible, $250 Copay, 20%		Ascension St. Vincent Employer Direct Network deductible and out of pocket amounts apply to **all levels** for emergency room services. Copay waived upon admittance.
	Emergency medical transportation	After In-Network Deductible, 20%		None
	Urgent care	After In-Network Deductible, $50 Copay		Copay includes the office visit charge only. All other services will be subject to deductible/coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	After Deductible, 20%	After Deductible, 50%	Precertification required, failure to do so will result in a $250 reduction in benefits.
	Physician/surgeon fees	After Deductible, 20%	After Deductible, 50%	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	After Deductible, $25 Copay	After Deductible, 50%	Copay includes the office visit charge only. All other services will be subject to deductible/coinsurance. Marriage, sex, family, career and financial counseling are not covered.
	Inpatient services	After Deductible, 20%	After Deductible, 50%	Precertification required, failure to do so will result in a $250 reduction in benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	Same as any other Illness or as required by the Affordable Care Act.		Coverage for all covered persons.
If you need help recovering or have other special health needs	Home health care	After Deductible, 20%	After Deductible, 50%	None
	Rehabilitation services	After Deductible, 20%	After Deductible, 50%	Precertification required for inpatient rehabilitation, failure to do so will result in a $250 reduction in benefits.
	Habilitation services	Not Covered		None
	Skilled nursing care	After Deductible, 20%	After Deductible, 50%	Precertification required, failure to do so will result in a $250 reduction in benefits.
	Durable medical equipment	After Deductible, 20%	After Deductible, 50%	None
	Hospice services	After Deductible, 20%	After Deductible, 50%	None
If your child needs dental or eye care	Children's eye exam	$15 copay (VSP Provider)		No Deductible.
	Children's glasses	$15 copay		Frames are limited to one every 24 months.
	Children's dental check-up	No Charge	Not Covered	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
- Dental Care (Adult)
- Infertility treatment
- Long term care
- Routine foot care (Unless medically necessary for the treatment of a metabolic or peripheral-vascular disease.)
- Weight loss programs

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

- Bariatric surgery (When medically necessary for the treatment of morbid obesity.)
- Chiropractic care (limited to 24 visits per calendar year)
- Cosmetic surgery (when medically necessary)
- Hearing aids
- Non-emergency care when traveling outside the U.S. (Unless covered person traveled to that location to receive services, supplies, and/or treatment.)
- Private duty nursing
- Routine eye care (all covered persons)

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: Stephanie Ford, Human Resources Department at Zionsville Community Schools at 1-317-873-2858 extension 11330, 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 1-765-608-6680.

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 1-765-608-6680

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-765-608-6680]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-765-608-6680]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-765-608-6680]

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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	**$2,400**
Specialist *copayment*	**$50**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,420**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,400**
Specialist *copayment*	**$50**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,800**

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

The plan's overall deductible	**$2,400**
Specialist *copayment*	**$50**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,480**

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