This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.UnifiedGrp.com or by calling your Unified Claims Account Manager at 1-800-291-5837.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Single / Family **$5,000** / **$10,000** In-Network **$7,500** / **$15,000** Out-of-Network Employer provides HRA and Muncie 105 contributions to help offset the deductible. The 1st $1,000 single/$2,000 family deductible is covered at 100% by the HRA. After an additional $1,000 single/$2,000 family deductible has been satisfied, the Muncie 105 will cover the next $3,000 single/$6,000 family at 100%.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	NO	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Single / Family **$5,000** / **$10,000** In-Network **$7,500** / **$15,000** Out-of-Network **$1,350** / **$2,700** Prescription Drugs Includes Deductible	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	NO	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	YES. For a list of **preferred providers**, see Encircle/Encore Health Network at www.encoreconnect.com or call 1-888-446-5844.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	NO	You can see the **specialist** you choose without permission from this plan
Are there services this plan doesn't cover?	YES	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use In Network providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	After Deductible, No Charge	After Deductible, No Charge	None
	Specialist visit	After Deductible, No Charge	After Deductible, No Charge	None
	Other practitioner office visit	After Deductible, No Charge	After Deductible, No Charge	Chiropractic routine maintenance is not covered.
	Preventive care/screening/immunization	No Charge	After Deductible, No Charge	As required by the Affordable Care Act. Deductible does not apply In Network.
If you have a test	Diagnostic test (x-ray, blood work)	After Deductible, No Charge	After Deductible, No Charge	None
	Imaging (CT/PET scans, MRIs)	After Deductible, No Charge	After Deductible, No Charge	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.true-rx.com	Generic drugs	$5 Copay		Prescription Drugs Out-of-Pocket Max: Single $1,350/ Family $2,700 Available through participating pharmacies or through the mail order program. Available in 30 or 90 day supplies.
	Preferred brand drugs	25% Copay		
	Non-preferred brand drugs	35% Copay		
	Specialty drugs	Same a Preferred or Non-preferred Brand.		Some specialty drugs may be covered under the medical portion of this plan.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After Deductible, No Charge	After Deductible, No Charge	None
	Physician/surgeon fees	After Deductible, No Charge	After Deductible, No Charge	None
If you need immediate medical attention	Emergency room services	After Deductible, No Charge		In Network Deductible and Out of Pocket amounts apply to both In and Out of Network for emergency room services.
	Emergency medical transportation	After Deductible, No Charge	After Deductible, No Charge	None
	Urgent care	After Deductible, No Charge	After Deductible, No Charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	After Deductible, No Charge	After Deductible, No Charge	Precertification required, failure to do so will result in a $250 reduction in benefits.
	Physician/surgeon fee	After Deductible, No Charge	After Deductible, No Charge	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	After Deductible, No Charge	After Deductible, No Charge	Marriage counseling is a covered expense.
	Mental/Behavioral health inpatient services	After Deductible, No Charge	After Deductible, No Charge	Precertification required, failure to do so will result in a $250 reduction in benefits.
	Substance use disorder outpatient services	After Deductible, No Charge	After Deductible, No Charge	None
	Substance use disorder inpatient services	After Deductible, No Charge	After Deductible, No Charge	Precertification required, failure to do so will result in a $250 reduction in benefits.
If you are pregnant	Prenatal and postnatal care	After Deductible, No Charge	After Deductible, No Charge	Coverage limited to Employee and Spouse only.
	Delivery and all inpatient services	Or as required by the Affordable Care Act.		

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	After Deductible, No Charge	After Deductible, No Charge	None
	Rehabilitation services	After Deductible, No Charge	After Deductible, No Charge	Precertification required for inpatient rehabilitation, failure to do so will result in a $250 reduction in benefits. Limited to 60 days per confinement.
	Habilitation services	Not Covered		None
	Skilled nursing care	After Deductible, No Charge	After Deductible, No Charge	Precertification required, failure to do so will result in a $250 reduction in benefits. Limited to 60 days per confinement.
	Durable medical equipment	After Deductible, No Charge	After Deductible, No Charge	None
	Hospice service	After Deductible, No Charge	After Deductible, No Charge	With 6 month life expectancy.
If your child needs dental or eye care	Eye exam	No Charge	After Deductible, No Charge	Limited to visual acuity prevention by a Primary Care Physician for children through age 5. Deductible does not apply In Network.
	Glasses	Not Covered		None
	Dental check-up	No Charge	After Deductible, No Charge	Limited to dental caries prevention by a Primary Care Physician for preschool age children. Deductible does not apply In Network.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Dental Care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (Only when medically necessary and approved by the Utilization Review Company.)
- Chiropractic Care
- Cosmetic surgery (Only when medically necessary as specified in the Plan Document.)
- 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 necessary for the treatment of metabolic or peripheral-vascular disease.)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your Human Resources Department at 1-765-747-5222. You may also contact 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."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Unified Group Services Appeal Department at 1-800-291-5837 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.do.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,900
- **Patient pays** $4,640

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$4,600
Co-pays	$10
Co-insurance	$0
Limits or exclusions	$30
Total	**$4,640**

Please Note: These totals do not include HRA contributions.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,960
- **Patient pays** $ 1,440

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,200
Co-pays	$200
Co-insurance	$0
Limits or exclusions	$40
Total	**$1,440**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.