
 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 or see [www.UnifiedGrp.com](http://www.UnifiedGrp.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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call your Human Resources Department at Martin Family Farms at 1-765-164-4440 to request a copy.

Important Questions	Answers	Why This Matters:									
What is the overall <a href="#">deductible</a> ?	<table border="1"> <tr> <td>Single</td> <td>Family</td> <td></td> </tr> <tr> <td>\$7,500</td> <td>\$15,000</td> <td>In-Network</td> </tr> <tr> <td>\$15,000</td> <td>\$30,000</td> <td>Out-of-Network</td> </tr> </table> <p>Those who complete the required health screening will receive their choice of a \$500 reduction in deductible OR 10% off their premium.</p>	Single	Family		\$7,500	\$15,000	In-Network	\$15,000	\$30,000	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> .
Single	Family										
\$7,500	\$15,000	In-Network									
\$15,000	\$30,000	Out-of-Network									
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , Physician office visits, Urgent Care 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> .									
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.									
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<table border="1"> <tr> <td>Single</td> <td>Family</td> <td></td> </tr> <tr> <td>\$8,150</td> <td>\$16,300</td> <td>In-Network</td> </tr> <tr> <td>\$16,300</td> <td>\$32,600</td> <td>Out-of-Network</td> </tr> </table> <p><b>Includes Deductible</b></p>	Single	Family		\$8,150	\$16,300	In-Network	\$16,300	\$32,600	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 own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket</a> limit has been met.
Single	Family										
\$8,150	\$16,300	In-Network									
\$16,300	\$32,600	Out-of-Network									
What is not included in the <a href="#">out-of-pocket limit</a> ?	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> .									
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of <a href="#">preferred providers</a> , see Cigna at <a href="http://www.cigna.com">www.cigna.com</a> or call 1-800-291-5837.	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.									
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 Copay/visit	After Deductible, 50%	Copayment applies to office visit charge only. All other services will be deductible/coinsurance.
	<a href="#">Specialist</a> visit	\$60 Copay/visit	After Deductible, 50%	Copayment applies to office visit charge only. All other services will be deductible/coinsurance.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	As required by the Affordable Care Act. Deductible and coinsurance do not apply.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	After Deductible, 20%	After Deductible, 50%	None
	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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.envisionrx.com">www.envisionrx.com</a>	Generic drugs	Pharmacy - \$10 Copay Mail Order - \$25 Copay		Pharmacy – 30 Day Supply Mail Order – 90 Day Supply
	Preferred brand drugs	Pharmacy - \$35 Copay Mail Order - \$87.50 Copay		
	Non-preferred brand drugs	Pharmacy - \$60 Copay Mail Order - \$150 Copay		
	<a href="#">Specialty drugs</a>	NOT COVERED		Please see your plan document for specific details.

\* 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
		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	<a href="#">Emergency room care</a>	After In-Network Deductible, 20%		In-Network Out-of-Pocket applies to both In and Out of Network.
	<a href="#">Emergency medical transportation</a>	After In-Network Deductible, 20%		None
	<a href="#">Urgent care</a>	\$100 Copay/visit	After Deductible, 50%	Copayment applies to office visit charge only. All other services will be 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	No Charge	After Deductible, 50%	Deductible and coinsurance do not apply In-Network.
	Inpatient services	After Deductible, 20%	After Deductible, 50%	Precertification required, failure to do so 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 or covered Employee and Spouse Only.
	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	After Deductible, 20%	After Deductible, 50%	Limited to 60 visits per calendar year.
	<a href="#">Rehabilitation services</a>	After Deductible, 20%	After Deductible, 50%	Precertification required for inpatient rehabilitation services, failure to do so will result in a \$250 reduction in benefits. Limited to 60 days per calendar year. Physical, Occupational and Speech Therapies are limited to 25 visits each per Calendar year with a \$30 Copay per visit per therapy.
	<a href="#">Habilitation services</a>	Not Covered		None
	<a href="#">Skilled nursing care</a>	After Deductible, 20%	After Deductible, 50%	Precertification required, failure to do so will result in a \$250 reduction in benefits. Limited to 60 days per year.
	<a href="#">Durable medical equipment</a>	After Deductible, 20%	After Deductible, 50%	None
	<a href="#">Hospice services</a>	After Deductible, 20%	After Deductible, 50%	With six (6) month life expectancy.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	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	Not Covered	Limited to dental caries prevention by a Primary Care Physician for preschool age children.

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

## 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)
- 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 20 visits per calendar year with a \$30 copay per visit.)
- Hearing Aids
- 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 Martin Family Farms at 1-765-164-4440, 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 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**

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](#).

### 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

-----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](#) \$7,500
- [Specialist copayment](#) \$60
- 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$7,500
Copayments	\$30
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$8,040</b>

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

- The [plan's](#) overall [deductible](#) \$7,500
- [Specialist copayment](#) \$60
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$1,230</b>

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

- The [plan's](#) overall [deductible](#) \$7,500
- [Specialist copayment](#) \$60
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>