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, call 1-800-792-3666 or visit ieshaffer.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.healthcare.gov/sbc-glossary or call 1-800-792-3666 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable	
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$** For network providers: $2,000 individual/$4,000 family; for out-of-network providers: no limit. For network pharmacy/prescription expenses: $500 individual/$1,000 family.	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?	Premiums, balance-billing charges and healthcare this plan doesn't 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.horizonblue.com or call1-800-810-2583 for a list of network providers.	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	$25 copay/office visit	Not covered	None
	Specialist visit	$25 copay/office visit	Not covered	Chiropractic coverage is limited to 25 visits/individual per calendar year
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$5 copay retail, 30 day supply, $10 copay mail order, 90 day supply	Not covered	The maximum out-of-pocket prescription expense is $2,500 person/$5,000 family. This is a separate limit from the medical benefit.
	Preferred brand drugs	20% copay (Retail min. copay of $20 and max. of $50/Mail order min. copay of $40 and max. of $100).	Not covered	The maximum out-of-pocket prescription expense is $2,500 person/$5,000 family. This is a separate limit from the medical benefit
	Non-preferred brand drugs	No Generic Available-30% copay (retail minimum copay of $35, maximum copay of $75/mail order min. copay of $70, max. copay of $150). Generic Available-retail $5 plus cost differential between brand and generic/mail order $10 plus cost differential between brand and generic.	Not covered	Plan is mandatory generic. The dispense as written penalty for receiving a brand name medication that has a FDA approved generic substitute is the applicable generic co-pay plus the difference in cost between the brand name and generic medication. This penalty is not subject to the maximum co-pay limitations.

[* For more information about limitations and exceptions, see the plan or policy document at ieshaffer.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)	
	Specialty drugs	20% copay, minimum $35, maximum $250	Not covered	Maximum 30 day supply. The annual maximum out-of-pocket expense for specialty medications is $2,500.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after $100 copay	Not covered	None
	Physician/surgeon fees	10% co-insurance	Not covered	None
If you need immediate medical attention	Emergency room care	$200 copay	$200 copay	$200 copay will be waived if admitted within 24 hours
	Emergency medical transportation	10% co-insurance	10% co-insurance	Covers transport if emergent and medically necessary.
	Urgent care	$25 copay/office visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after $500 copay	Not covered	Pre-certification requirements apply. Non-compliance will result in no coverage.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office setting-$25 copay, Out-patient-$25 copay	Not covered	None
	Inpatient services	10% coinsurance after $500 copay	Not covered	Pre-certification requirements apply. Non-compliance will result in no coverage.
If you are pregnant	Office visits	$25 copay/1st office visit	Not covered	None
	Childbirth/delivery professional services	10% coinsurance	Not covered	None
	Childbirth/delivery facility services	10% coinsurance after $500 copay	Not covered	Pre-certification requirements apply. Non-compliance will result in a 20% penalty.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	4 hours = 1 visit. No custodial care covered.
	Rehabilitation services	$25 copay/visit for out-patient. For in-patient, 10% coinsurance.	Not covered	Short-term therapy is limited to 30 visits/year. In-patient rehabilitation is limited to 60 days/year.
	Habilitation services	$25 copay/visit for out-patient. For in-patient, 10% co-insurance.	Not covered	Costs may vary depending on the center that provides the service.

[* For more information about limitations and exceptions, see the plan or policy document at ieshaffer.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)	
	Skilled nursing care	10% coinsurance	Not covered	Limited to 100 days/year. Medical treatment only.
	Durable medical equipment	10% coinsurance	Not covered	Rental only up to purchase price. No personal hygiene equipment is covered.
	Hospice services	10% coinsurance	Not covered	Excludes pastoral care and counseling. 10 day respite limit.
If your child needs dental or eye care	Children's eye exam	Refer to Davis Vision Benefit	Not covered	Child vision screening covered under preventative care benefit.
	Children's glasses	Refer to Davis Vision Benefit	Not covered	
	Children's dental check-up	Refer to your dental plan	Not covered	Oral health risk assessment covered under preventative.

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 (except for certain surgical procedures, TMJ and treatment for children under 6 years of age)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Routine Foot Care
- 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 (30 visits per person per year)
- Non-emergency care when traveling outside the U.S. (excludes procedures not available in the U.S.)
- Private Duty Nursing (not in hospital)
- Routine Eye Care (adult)

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 Benefit Security Administration at 1-866-444-EBSA 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 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: : I.E. Shaffer & Co., P.O. Box 1028, West Trenton, NJ 08628, or you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov.ebsa/healthreform.

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 1-800-792-3666

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

[* For more information about limitations and exceptions, see the plan or policy document at ieshaffer.com]

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	**$0**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**10%**
Other *[cost sharing]*	**10%**

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	$500
Copayments	$30
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1390**

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**10%**
Other *[cost sharing]*	**10%**

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	$0
Copayments	$400
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1120**

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

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**10%**
Other *[cost sharing]*	**10%**

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	$0
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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