




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 ieshafter.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 : \$2,500 individual/\$5,000 family; for out-of-network providers : no limit. For network pharmacy/prescription expenses :\$4,100 individual/\$8,200 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 call 1-800-810-2583 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	\$30 copayment /office visit	Not covered	None
	Specialist visit	\$30 copayment /office visit	Not covered	Chiropractic coverage is limited to 30 visits/individual or 40 visits/family per calendar year
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Out-of-network tests are not covered except for services rendered by hospital based pathologists and radiologists at in-network hospitals. \$30 copayment if performed in doctor's office.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Out-of-network tests are not covered except for services rendered by hospital based pathologists and radiologists at in-network hospitals.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	\$3 copayment /retail, \$6 copayment /mail order	Not covered	The maximum out-of-pocket prescription expense is \$4,100 person/\$8,200 family. This is a separate limit from the medical benefit.
	Preferred brand drugs	20% coinsurance , \$150 max. for retail, 20% coinsurance , \$300 max. for mail order.	Not covered	The maximum out-of-pocket prescription expense is \$4,100 person/\$8,200 family. This is a separate limit from the medical benefit
	Non-preferred brand drugs	50% copayment /retail, 50% copayment /mail order.	Not covered	Plan is mandatory generic. The maximum out-of-pocket prescription expense is \$4,100 person/\$8,200 family. This is a separate limit from the medical benefit.
	Specialty drugs	20% copayment , \$200 maximum for preferred brand, \$250 maximum for non-preferred.	Not covered	\$2,500 annual copay limit.

[* 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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	\$200 <u>copayment</u> which is waived if admitted	\$200 <u>copayment</u> which is waived if admitted	<u>Out-of-network</u> coverage for emergency services rendered in an emergency department of a hospital will be provided on the same basis as <u>in-network</u> coverage.
	Emergency medical transportation	No charge	No charge	Covers transport from point where stricken to nearest hospital that can provide treatment.
	Urgent care	\$30 <u>copayment</u> /office visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	<u>Preauthorization</u> 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	\$30 <u>copayment</u> /office visit	Not covered	None
	Inpatient services	No charge	Not covered	<u>Preauthorization</u> requirements apply. Non-compliance will result in no coverage.
If you are pregnant	Office visits	\$30 <u>copayment</u> /1 st office visit	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	<u>Preauthorization</u> requirements apply. Non-compliance will result in no coverage.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Maximum 200 visits/year. 4 hours = 1 visit. No custodial care covered. <u>Preauthorization</u> requirements apply.
	Rehabilitation services	\$30 <u>copayment</u> /visit for out-patient. For in-patient, see hospital stay facility fee benefit.	Not covered	After 6 months, medical necessity will be reviewed.
	Habilitation services	\$30 <u>copayment</u> /visit for	Not covered	None

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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)	
		out-patient. For in-patient, see hospital stay facility fee benefit		
	Skilled nursing care	No charge for out-patient. For in-patient see hospital stay facility fee benefit.	Not covered	Medical treatment only.
	Durable medical equipment	No charge	Not covered	Rental only up to purchase price. No personal hygiene equipment is covered.
	Hospice services	In-patient – see hospital stay facility fee benefit. Out-patient – see home health care benefit.	Not covered	Excludes respite care, pastoral care and counseling.
If your child needs dental or eye care	Children’s eye exam	No charge up to \$300 overall vision maximum/calendar year	No charge up to \$300 overall vision maximum/calendar year	Child vision <u>screening</u> covered under <u>preventative</u> care benefit. See additional vision coverage.
	Children’s glasses	No charge up to \$300 overall vision maximum/calendar year	No charge up to \$300 overall vision maximum/calendar year	None
	Children’s dental check-up	No charge	No charge	Dental check-up covered under selected dental plan, once every 6 months. Oral health risk assessment covered under <u>preventative</u> care benefit. See additional dental coverage.

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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](#).)

- Cosmetic Surgery
- Long Term Care
- Weight Loss Programs
- Infertility Treatment
- Hearing Aids

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

- Acupuncture
- Bariatric Surgery (approval needed based on medical necessity)
- Chiropractic Care (30 visits per person/40 visits per family per year)
- Dental Care
- 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)
- Routine Foot Care

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.

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 \[cost sharing\]](#) \$30
- Hospital (facility) [\[cost sharing\]](#) 0%
- Other [\[cost sharing\]](#) 0%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$40
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$100

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 \[cost sharing\]](#) \$30
- Hospital (facility) [\[cost sharing\]](#) 0%
- Other [\[cost sharing\]](#) 0%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$30
- Hospital (facility) [\[cost sharing\]](#) 0%
- Other [\[cost sharing\]](#) 0%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$400

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.