




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 us at [www.ieshaffer.com](http://www.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 <https://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 <a href="#">deductible</a> ?	\$0 <a href="#">in-network</a> , \$500 individual or \$1,500 family <a href="#">out-of-network</a> .	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 <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$3,600 individual/\$7,200 family; for <a href="#">out-of-network providers</a> \$10,000 individual/\$10,000 family. For <a href="#">network pharmacy/prescription expenses</a> : \$3,000 individual/\$6,000 family.	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 limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing charges</a> and healthcare this <a href="#">plan</a> doesn't cover.	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. See <a href="http://www.horizonblue.com">www.horizonblue.com</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> .	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	\$10 <a href="#">copay</a> /office visit	<a href="#">Deductible</a> and 50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /office visit	<a href="#">Deductible</a> and 50% <a href="#">coinsurance</a>	Chiropractic coverage is limited to 30 visits/individual per calendar year for both in and out of network services.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	Urine drug <a href="#">screenings</a> are not covered.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	<a href="#">Deductible</a> and 50% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> tests are not covered except for services rendered by hospital based pathologists and radiologists. In NJ, participants must use Lab Corp. \$10 <a href="#">copay</a> if performed in doctor's office.
	Imaging (CT/PET scans, MRIs)	No charge	<a href="#">Deductible</a> and 50% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> 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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.welldynex.com">www.welldynex.com</a>	Generic drugs	\$5 <a href="#">copay</a> /retail, \$5 <a href="#">copay</a> /mail order	Not covered	The maximum <a href="#">out-of-pocket</a> prescription expense is \$3,000 person/\$6,000 family. This is a separate limit from the medical benefit.
	Preferred brand drugs	\$20 <a href="#">copay</a> /retail, \$35 <a href="#">copay</a> /mail order	Not covered	The maximum <a href="#">out-of-pocket</a> prescription expense is \$3,000 person/\$6,000 family. This is a separate limit from the medical benefit.
	Non-preferred brand drugs	\$30 <a href="#">copay</a> /retail, \$50 <a href="#">copay</a> /mail order	Not covered	Plan is mandatory generic. The maximum <a href="#">out-of-pocket</a> prescription expense is \$3,000 person/\$6,000 family. This is a separate limit from the medical benefit.
	<a href="#">Specialty drugs</a>	20% <a href="#">copay</a> , \$200 max. for preferred brand, \$250 max. for non-preferred brand	Not covered	\$2,000 annual <a href="#">copay</a> limit per person.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None

[\* For more information about limitations and exceptions, see the plan or policy document at [www.ieshaffer.com](http://www.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)	
	Physician/surgeon fees	No charge	<u>Deductible</u> and 50% <u>coinsurance</u>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <u>copay</u> which is waived if admitted.	Emergency services - \$50 <u>copay</u> which is waived if admitted/Non-Emergency services - \$50 <u>copay</u> which is waived if admitted and then <u>deductible</u> and 50% <u>coinsurance</u> .	<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 in-network coverage.
	<a href="#">Emergency medical transportation</a>	No charge	<u>Deductible</u> and 50% <u>coinsurance</u>	Covers transport from point where stricken to nearest hospital that can provide treatment.
	<a href="#">Urgent care</a>	\$10 <u>copay/office visit</u>	<u>Deductible</u> and 50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	<u>Deductible</u> and 50% <u>coinsurance</u>	Pre-certification requirements apply. Non-compliance will result in no coverage.
	Physician/surgeon fees	No charge	<u>Deductible</u> and 50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay/office visit</u>	<u>Deductible</u> and 50% <u>coinsurance</u>	None
	Inpatient services	No charge	<u>Deductible</u> and 50% <u>coinsurance</u>	Pre-certification requirements apply. Non-compliance will result in no coverage.
If you are pregnant	Office visits	\$ 10 <u>copay/1<sup>st</sup> visit</u>	<u>Deductible</u> and 50% <u>coinsurance</u>	None
	Childbirth/delivery professional services	No charge	<u>Deductible</u> and 50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No charge	<u>Deductible</u> and 50% <u>coinsurance</u>	Pre-certification requirements apply. Non-compliance will result in no coverage.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	<u>Deductible</u> and 50% <u>coinsurance</u>	Maximum 120 visits/year.4 hours = 1 visit. No custodial care covered.
	<a href="#">Rehabilitation services</a>	\$10 <u>copay/visit</u> for out-patient. For in-patient, see hospital stay facility fee benefit.	<u>Deductible</u> and 50% <u>coinsurance</u>	After 6 months, medical necessity will be reviewed.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None

[\* For more information about limitations and exceptions, see the plan or policy document at [www.ieshaffer.com](http://www.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)	
	<a href="#">Skilled nursing care</a>	\$10 <u>copay</u> /visit for out-patient. For in-patient see hospital stay facility fee benefit.	<u>Deductible</u> and 50% <u>coinsurance</u>	Maximum 120 days/year. Medical treatment only.
	<a href="#">Durable medical equipment</a>	No charge	<u>Deductible</u> and 50% <u>coinsurance</u>	Rental only up to purchase price. No personal hygiene equipment is covered.
	<a href="#">Hospice services</a>	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	No charge	Child vision screening covered under preventative care benefit. See additional vision benefit.
	Children's glasses	No charge	No charge	Maximum vision allowance is \$500 per person every calendar year (for eye exam and glasses/contacts combined).
	Children's dental check-up	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Dental check-up covered under selected dental plan, once every 6 months. Oral health risk assessment covered under preventative care benefit. See additional dental benefit.

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

- Cosmetic Surgery
- Long Term Care
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery (must be approved, based on medical necessity)
- Chiropractic Care (30 visits per person per calendar year)
- Dental Care
- Hearing Aids (up to age 15-unlimited benefit/age 15 and older -up to \$2,000/36 consecutive months)
- Infertility Treatment (\$20,000 per person lifetime maximum plus an additional \$40,000 per person lifetime maximum subject to a 50% copay). Plan will cover artificial insemination and prescription fertility drugs as unlimited benefits
- Non-emergency care when traveling outside the U.S. (excludes procedures not available in 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](http://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](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: : 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](http://www.dol.gov/ebsa/healthreform).

**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 1-800-792-3666

-----*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 copayment](#) \$10
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$260</b>

**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 copayment](#) \$10
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$560</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$50
- Other [coinsurance](#) 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$70</b>