




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	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable.	
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</a> providers: \$4,000 individual/\$8,000 family; for out-of-network providers: no limit. For <a href="#">network</a> pharmacy/prescription expenses: \$2,600 individual/\$5,200 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 provider <a href="#">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	\$25 <a href="#">copay</a> /office visit	Not covered	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /office visit	Not covered	Chiropractic coverage is limited to 30 visits/individual per calendar year.
	<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)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Out-of-network</a> tests are not covered except for services rendered by hospital based pathologists and radiologists at <a href="#">in-network</a> hospitals. In NJ, participants must use Lab Corp. of America. \$25 <a href="#">copay</a> if performed in doctor's office.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Out-of-network</a> tests are not covered except for services rendered by hospital based pathologists and radiologists at <a href="#">in-network</a> hospitals. \$25 <a href="#">copay</a> if performed in doctor's office.
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	\$5 <a href="#">copay</a> /retail \$10 <a href="#">copay</a> /90 day supply mail order.	Not covered	The maximum <a href="#">out-of-pocket</a> prescription expense is \$2,600 person/\$5,200 family. This is a separate limit from the medical benefit plan.
	Preferred brand drugs	60% <a href="#">copay</a> /retail. 60% <a href="#">copay</a> /90 day supply mail order.	Not covered	The maximum <a href="#">out-of-pocket</a> prescription expense is \$2,600 person/\$5,200 family. This is a separate limit from the medical benefit plan.
	Non-preferred brand drugs	100% <a href="#">copay</a> /retail. 100% <a href="#">copay</a> /90 day supply mail order.	Not covered	Plan is mandatory generic. The maximum <a href="#">out-of-pocket</a> prescription expense is \$2,600 person/\$5,200 family. This is a separate limit from the medical benefit plan.
	<a href="#">Specialty drugs</a>	20% <a href="#">copay</a> , maximum of \$200(Preferred). 20% <a href="#">copay</a> , maximum of \$250.(Non-Preferred)	Not covered	The maximum <a href="#">out-of-pocket</a> prescription expense is \$2,600 person/\$5,200 family. This is a separate limit from the medical benefit plan.

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)	20% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <u>copay</u> which is waived if admitted, 20% <u>coinsurance</u>	\$50 <u>copay</u> which is waived if admitted, 20% <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 <u>in-network</u> coverage.
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Covers transport from point where stricken to nearest hospital that can provide treatment.
	<a href="#">Urgent care</a>	\$25 <u>copay</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	Pre-certification requirements apply. Non-compliance will result in no coverage.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /office visit	Not covered	None
	Inpatient services	20% <u>coinsurance</u>	Not covered	Pre-certification requirements apply. Non-compliance will result in no coverage.
If you are pregnant	Office visits	\$ 25 <u>copay</u> /1 <sup>st</sup> visit	Not covered	None
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	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>	20% <u>coinsurance</u>	Not covered	Maximum 120 visits/year. 4 hours = 1 visit. No custodial care covered.
	<a href="#">Rehabilitation services</a>	\$25 <u>copay</u> /visit for out-patient. For in-patient, see hospital stay facility fee benefit.	Not covered	After 6 months, medical necessity will be reviewed.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	No charge for out-patient. For in-patient see hospital stay facility fee benefit.	Not covered	Maximum 150 days/year. Medical treatment only.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	Not covered	Rental only up to purchase price. No personal

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="#">Hospice services</a>	In-patient – see hospital stay facility fee benefit. Out-patient – see home health care benefit.	Not covered	hygiene equipment is covered. 180 days, \$10,000 lifetime maximum. Excludes respite care, pastoral care and counseling.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child vision <u>screening</u> covered under preventative care benefit. See additional vision benefit.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Oral health risk assessment covered under preventative care benefit. See additional dental benefit.

### 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](#).)

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|--|--|---|
| <ul style="list-style-type: none"><li>• Cosmetic Surgery</li></ul> | <ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Infertility Treatment</li></ul> | <ul style="list-style-type: none"><li>• Long term Care</li><li>• Weight Loss Programs</li></ul> |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery (approval needed based on medical necessity)</li><li>• Chiropractic Care (30 visits per person per calendar year)</li><li>• Dental Care</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S. (excludes procedures not available in the U.S.)</li><li>• Private Duty Nursing (not in hospital)</li><li>• Routine Eye Care (adult)</li></ul> | <ul style="list-style-type: none"><li>• Routine Foot Care</li></ul> |
|---|--|---|

**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](#) \$25
- 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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,560</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](#) \$25
- 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>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,960</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$25
- Hospital (facility) [copayment](#) \$50
- 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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>