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. 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 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: $4,000 individual/$8,000 family; for out-of-network providers: no limit. For network pharmacy/prescription expenses: $2,600 individual/$5,200 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 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 30 visits/individual per calendar year.
	Preventive care/screening/ immunization	No charge	Not covered	Urine drug screenings are 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. In NJ, participants must use Lab Corp. of America. $25 copay 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. $25 copay if performed in doctor's office.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Generic drugs	$5 copay /retail. $10 copay/90 day supply mail order.	Not covered	The maximum out-of-pocket prescription expense is $2,600 person/$5,200 family. This is a separate limit from the medical benefit plan.
	Preferred brand drugs	35% copay, minimum of $20, maximum of $150/retail. 35% copay minimum of $40, maximum of $300/90 day supply mail order.	Not covered	The maximum out-of-pocket prescription expense is $2,600 person/$5,200 family. This is a separate limit from the medical benefit plan.
	Non-preferred brand drugs	50% copay, minimum of $35/retail. 50% copay, minimum of $55/90 day supply mail order.	Not covered	Plan is mandatory generic. The maximum out-of-pocket prescription expense is $2,600 person/$5,200 family. This is a separate limit from the medical benefit plan.

[* For more information about limitations and exceptions, see the plan or policy document at 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)	
	Specialty drugs	20% copay, maximum of $200(Preferred). 20% copay, maximum of $250(Non-preferred)	Not covered	The maximum out-of-pocket prescription expense is $2,600 person/$5,200 family. This is a separate limit from the medical benefit plan.
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	$50 copay which is waived if admitted	$50 copay which is waived if admitted	Out-of-network coverage for emergency services rendered in an emergency department of a hospital will be provided on the same basis as in-network coverage.
	Emergency medical transportation	No charge	No charge	Covers transport from point where stricken to nearest hospital that can provide treatment.
	Urgent care	$25 copay	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	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	$25 copay/office visit	Not covered	None
	Inpatient services	No charge	Not covered	Pre-certification requirements apply. Non-compliance will result in no coverage.
If you are pregnant	Office visits	$ 25 copay/1st visit	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	Pre-certification 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 120 visits/year.4 hours = 1 visit. No custodial care covered.
	Rehabilitation services	$25 copay/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	Not covered	Not covered	None

[* For more information about limitations and exceptions, see the plan or policy document at 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)	
	Skilled nursing care	No charge for out-patient. For in-patient see hospital stay facility fee benefit.	Not covered	Maximum 150 days/year. 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	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	No charge/12 consecutive months	$50 maximum benefit/12 consecutive months	Child vision screening covered under preventative care benefit. See additional vision benefits.
	Children's glasses	Frames-$50, single vision lenses-$50, bifocal-$75, trifocal-$75, lenticular-$120, contacts-$150 max./12 consecutive months.	Frames-$50, single vision lenses-$50, bifocal-$75, trifocal-$75, lenticular-$120, contacts-$150 max./12 consecutive months.	
	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 preventative care benefit. See additional dental benefits.

[* For more information about limitations and exceptions, see the plan or policy document at 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	• Hearing Aids • Infertility Treatment	• 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 (approval needed based on medical necessity) • Chiropractic Care (30 visits per person per calendar 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 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
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.

[* For more information about limitations and exceptions, see the plan or policy document at www.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 *copayment*	$25
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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$560

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*	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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,760

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*	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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$180

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