




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](http://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](http://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 <a href="#">deductibles</a> 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> : \$4,000 individual/\$8,000 family; for <a href="#">out-of-network providers</a> : no limit. For <a href="#">network pharmacy/prescription expenses</a> : \$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 <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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 office or clinic</a>	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a> /office visit	Not covered	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copayment</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	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	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="#">copayment</a> if performed in doctor's office.
	Imaging (CT/PET scans, MRIs)	No charge	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="#">copayment</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="#">www.[insert].com</a>	Generic drugs	\$5 <a href="#">copayment</a> /retail. \$10 <a href="#">copayment</a> /90 day supply mail order.	Not covered	The <a href="#">maximum out-of-pocket</a> prescription expense is \$2,600 person/\$5,200 family. This is a separate limit from the medical benefit.
	Preferred brand drugs	35% <a href="#">copayment</a> , minimum of \$20, maximum of \$150/retail. 35% <a href="#">copayment</a> minimum of \$40, maximum of \$300/90 day supply mail order.	Not covered	The <a href="#">maximum out-of-pocket</a> prescription expense is \$2,600 person/\$5,200 family. This is a separate limit from the medical benefit
	Non-preferred brand drugs	50% <a href="#">copayment</a> , minimum of \$35/retail. 50% <a href="#">copayment</a> , minimum of \$55/90 day supply mail order.	Not covered	<a href="#">Plan</a> 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.

[\* 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)	
	<a href="#">Specialty drugs</a>	20% <u>copayment</u> , maximum of \$200 (Preferred). 20% <u>copayment</u> , maximum of \$250 (Non-preferred)	Not covered	The maximum <u>out-of-pocket</u> 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	<a href="#">Emergency room care</a>	\$50 <u>copayment</u> which is waived if admitted	\$50 <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.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	Covers transport from point where stricken to nearest hospital that can provide treatment.
	<a href="#">Urgent care</a>	\$25 <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	\$25 <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	\$25 <u>copayment</u> /1 <sup>st</sup> 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	<a href="#">Home health care</a>	No charge	Not covered	Maximum 120 visits/year. 4 hours = 1 visit. No custodial care covered. <u>Preauthorization</u> requirements apply.

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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)	
<b>other special health needs</b>	<a href="#">Rehabilitation services</a>	\$25 <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.
	<a href="#">Habilitation services</a>	\$25 <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.
	<a href="#">Skilled nursing care</a>	No charge for out-patient. For in-patient see hospital stay facility fee benefit.	Not covered	Maximum 120 days/year. Medical treatment only.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	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	180 days, \$10,000 lifetime maximum. Excludes respite care, pastoral care and counseling.
<b>If your child needs dental or eye care</b>	Children’s eye exam	No charge/12 consecutive months	\$50 maximum benefit/12 consecutive months	Child vision <u>screening</u> covered under <u>preventative</u> care benefit. See additional vision coverage.
	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 <u>preventative</u> care benefit. See additional dental coverage.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [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
- 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 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](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 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](http://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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the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*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 \[cost sharing\]](#) \$25
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$90</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 \[cost sharing\]](#) \$25
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

**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) [\[cost sharing\]](#) \$50
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$50
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$250</b>

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