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 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 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 in-network, $300 individual or $600 family out-of-network. Aggregate family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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 health providers $4,500 individual/$9,000 family. For pharmacy providers $500 individual/$1,000 family. Combined in and out of network benefits. Aggregate 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. The maximum out-of-pocket limits are combined in and out of network.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care 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 1-800-792-3666 for a list of in- 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	$20 copayment per office visit	Deductible and 20% coinsurance	
	Specialist visit	$20 copayment per office visit	Deductible and 20% coinsurance	Chiropractic coverage is limited to 25 visits/individual per calendar year
	Preventive care/screening/ immunization	No charge	20% coinsurance	One per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for office, outpatient hospital, independent laboratory	Deductible and 20% coinsurance	
	Imaging (CT/PET scans, MRIs)	No charge for outpatient hospital	Deductible and 20% coinsurance	Imaging requires pre-approval (authorization).
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Prime Therapeutics LLC (Prime) Service Center www.MyPrime.com or 1-800-370-5088	Generic drugs	$10 copayment/30 day retail, $20 copayment/60 day retail, $30 copayment/90 day retail or $20 copayment/90 day mail order	$10 copayment/30 day retail, $20 copayment/60 day retail, $30 copayment/90 day retail or $20 copayment/90 day mail order	Prior Authorization may be required The maximum out-of-pocket prescription expense is $500 person/$1,000 family. This is a separate limit from the medical benefit.
	Preferred brand drugs	$25 copayment/30 day retail, $50 copayment/60 day retail, $75 copayment/90 day retail or $50 copayment/90 day mail order	$25 copayment/30 day retail, $50 copayment/60 day retail, $75 copayment/90 day retail or $50 copayment/90 day mail order	
	Non-preferred brand drugs	$50 copayment/30 day retail, $100 copayment/60 day retail, $150 copayment/90 day retail or $100	$50 copayment/30 day retail, $100 copayment/60 day retail, $150 copayment/90 day retail or $100 copayment/	

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)	
		copayment/90 day mail order	90 day mail order	
	Specialty drugs	Covered at retail benefit in above applicable categories	Covered at retail benefit in above applicable categories	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge for outpatient hospital, surgical center	Deductible and 20% coinsurance for outpatient hospital, surgical center	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
	Physician/surgeon fees	No charge for outpatient hospital, surgical center	Deductible and 20% coinsurance for outpatient hospital, surgical center	
If you need immediate medical attention	Emergency room care	$50 copayment which is waived if admitted	$50 copayment which is waived if admitted. Deductible does not apply.	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. Copayment waived if admitted within 24 hours.
	Emergency medical transportation	No charge	Deductible and 20% coinsurance	Covers transport if emergent and medically necessary
	Urgent care	$20 copayment per office visit	Deductible and 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Deductible and 20% coinsurance	Prior-authorization requirements apply. Non-compliance may result in no coverage.
	Physician/surgeon fees	No charge	Deductible and 20% coinsurance	Procedures related to spine surgery are subject to pre-service and post-service utilization management review.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for outpatient hospital	Deductible and 20% coinsurance	$20 copayment applies per professional office visit.
	Inpatient services	No charge for inpatient hospital	Deductible and 20% coinsurance	Prior authorization requirements apply. Non-compliance may result in no coverage.
If you are pregnant	Office visits	$20 copayment per office visit	Deductible and 20% coinsurance	Cost Sharing does not apply for preventative services. Not covered for child dependent

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)	
	Childbirth/delivery professional services	No charge	Deductible and 20% coinsurance	Not covered for child dependent. Prior authorization requirements apply. Non-compliance may result in no coverage.
	Childbirth/delivery facility services	No charge	Deductible and 20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	Deductible and 20% coinsurance	Out-of-network maximum 100 visits/year. 4 hours = 1 visit. No custodial care covered. Prior authorization requirements apply.
	Rehabilitation services	$20 copayment/visit for out-patient. For in-patient, see hospital stay facility fee benefit.	Deductible and 20% coinsurance	60 days per benefit period, combined in-network and out-of-network. Prior authorization requirements apply
	Habilitation services	$20 copayment/visit for out-patient. For in-patient, see hospital stay facility fee benefit.	Deductible and 20% coinsurance	
	Skilled nursing care	No charge for inpatient facility.	Deductible and 20% coinsurance	In-network maximum 100 days/year, out-of-network maximum 60 days/year. Medical treatment only. Prior authorization requirements apply
	Durable medical equipment	No charge	Deductible and 20% coinsurance	Prior authorization required for DME purchases over $500.
	Hospice services	No charge for inpatient facility.	Deductible and 20% coinsurance	Maximum 10 days of respite care. Excludes pastoral care and counseling.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child vision screening covered under preventive care benefit. See vision coverage.
	Children's glasses	Not covered	Not covered	See vision coverage
	Children's dental check-up	Not covered	Not covered	See dental coverage.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Long Term Care
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Bariatric Surgery
- Chiropractic Care (25 visits per person per calendar year)
- Hearing Aid and exam (15 and younger). One hearing aid for each impaired ear every 24 months
- Infertility Treatment ($20,000 per person per calendar year, $50,000 lifetime maximum. Limit 4 completed egg retrievals. Plan will cover IVF, GIFT, ZIFT and IUI. Diagnostic testing and medication not subject to maximum. Must contact Fund office for all benefit inquiries.
- Most coverage provided outside the United States. See www.HorizonBlue.com
- Non-emergency care when traveling outside the U.S. (excludes procedures not available in the U.S.)
- Private Duty Nursing (not in hospital)

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.

[* 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 *[copay]*	**$20**
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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

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 *[copay]*	**$20**
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

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

The plan's overall deductible	**$0**
Specialist *[copay]*	**$20**
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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**