




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. 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	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 : \$6,500 individual/\$13,000 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 call 1-800-810-2583 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	\$40 copayment /office visit	Not covered	None
	Specialist visit	\$40 copayment /office visit	Not covered	Chiropractic coverage is limited to 30 visits/individual per calendar year
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	Out-of-network tests are not covered except for services rendered by hospital based pathologists and radiologists at in-network hospitals. \$50 copayment if performed in doctor's office.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Out-of-network tests are not covered except for services rendered by hospital based pathologists and radiologists at in-network hospitals. \$50 copayment 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.[insert].com	Generic drugs	\$5 copayment /retail. \$10 copayment /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.
	Preferred brand drugs	60% copayment /retail. 60% copayment /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
	Non-preferred brand drugs	100% copayment /retail. 100% copayment /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.
	Specialty drugs	20% copayment , maximum of \$200 (Preferred). 20% copayment , maximum	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.

[* 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) of \$250 (Non-preferred)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	Emergency room care	\$200 <u>copayment</u> which is waived if admitted, 30% <u>coinsurance</u>	\$200 <u>copayment</u> which is waived if admitted, 30% <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.
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Covers transport from point where stricken to nearest hospital that can provide treatment.
	Urgent care	\$40 <u>copayment</u> /office visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> requirements apply. Non-compliance will result in no coverage.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copayment</u> /office visit	Not covered	None
	Inpatient services	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> requirements apply. Non-compliance will result in no coverage.
If you are pregnant	Office visits	\$40 <u>copayment</u> /1 st office visit	Not covered	None
	Childbirth/delivery professional services	30% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> requirements apply. Non-compliance will result in no coverage.
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	Not covered	Maximum 120 visits/year. 4 hours = 1 visit. No custodial care covered. <u>Preauthorization</u> requirements apply.
	Rehabilitation services	\$40 <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.

[* 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)	
	Habilitation services	\$40 <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.
	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	30% <u>coinsurance</u>	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	Not covered	Not covered	Child vision <u>screening</u> covered under <u>preventative</u> care benefit. See additional vision coverage.
	Children’s glasses	Not covered	Not covered	
	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.

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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. 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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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 \[cost sharing\]](#) \$40
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$40
Coinsurance	\$3,777
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,877

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 \[cost sharing\]](#) \$40
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1200
Coinsurance	\$1224
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2444

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$40
- Hospital (facility) [\[cost sharing\]](#) 30%
- Other [\[cost sharing\]](#) 30%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$780
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$980

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