**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 1-800-522-4161. 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.dol.gov/ebsa/healthreform or call 1-800-522-4161 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $250/Individual or $500/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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, prescription drug coverage, emergency room, dental, vision and primary care services are covered before you meet your 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?** | Yes. Out-of-network Dental: $15/individual or $30/family. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $1,500 individual (Medical - $1,350 & prescription drug coverage - $150)/$3,000 family ($2,700 & $300) | 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, vision and dental charges, penalties for failure to obtain preauthorization 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 (call 1-800-355-BLUE [2583]) or call 1-800-522-4161 for a list of network providers. | This plan uses a provider network and there is no coverage for out-of-network providers in most instances. You will pay less if you use a provider in the plan's network. |
| **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 copay/office visit | Not covered | No deductible |
| | Specialist visit | $30 copay/visit | Not covered | No deductible for office visit – unless surgical procedure performed. 10% coinsurance + deductible for acupuncture. |
| | Preventive care/screening/ immunization | No charge | Covered up to allowance if no provider within 50 miles. | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Age and frequency limits may apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge – Routine x-ray / Radiology & Lab | Not covered | Inpatient professional services for non-routine (diagnostic) x-ray / Radiology & lab and (diagnostic) Imaging – 10% coinsurance + deductible. |
| | Imaging (CT/PET scans, MRIs) | No charge – Routine Imaging | Not covered | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.express-scripts.com | Generic drugs | $5 copay/prescription (retail) & $10 copay/ prescription (mail order) | Not covered | Covers up to a 34-day supply (retail)/100 pills; 90-day supply of maintenance medications (mail order or mail at retail). |
| | Preferred brand drugs | $15 copay/prescription (retail ) & $30 copay/ prescription (mail order) | Not covered | |
| | Non-preferred brand drugs | $30 copay/prescription (retail ) & $60 copay/ prescription (mail order) | Not covered | |
| | Specialty drugs | $5/$15/$30 copays (retail) | Not covered | Covers up to a 34-day supply/100 pills. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | Not covered | Deductible applies; plan approval may be required for certain services. |
| | Physician/surgeon fees | 10% coinsurance | Not covered | Deductible applies. |
| **If you need immediate medical attention** | Emergency room care | $75 copay/visit | $75 copay/visit | Copay waived if admitted to hospital |
| | Emergency medical transportation | No charge for Air & Ground Emergency services /10% coinsurance for non- | No charge for Air & Ground Emergency services | No deductible for emergency services, deductible applies to in-network non-emergency services. |

| 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) | |
| | | emergency ambulance services | | |
| | Urgent care | 10% coinsurance | Not covered | Deductible applies. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | Not covered | Deductible applies; Preadmission Review & Individual Case Management. |
| | Physician/surgeon fees | 10% coinsurance | Not covered | Deductible applies. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay/office visit; otherwise 10% coinsurance + deductible for other outpatient services | Not covered | Contact Beacon Health Options (1-800-843-5503) to ensure that all services are covered.<br><br>Preauthorization required for inpatient services. |
| | Inpatient services | 10% coinsurance + deductible | Not covered | |
| **If you are pregnant** | Office visits | Office visits covered at 100% after $30 OB/Gyn copay for 1st visit | Not covered | None |
| | Childbirth/delivery professional services | 10% coinsurance | Not covered | Deductible applies. |
| | Childbirth/delivery facility services | 10% coinsurance | Not covered | Deductible applies; 48 Hr. minimum – vaginal delivery; 96 Hr. minimum – caesarean section. |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | Not covered | Deductible applies; services limited to 100 visits per calendar year. |
| | Rehabilitation services | 10% coinsurance – $30 copay/1st visit | Not covered | Deductible applies; services limited to 90 visits per calendar year. |
| | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | 10% coinsurance | Not covered | Deductible applies; maximum of 100 facility days per calendar year. |
| | Durable medical equipment | 10% coinsurance | Not covered | Deductible applies; preauthorization required – all rentals or purchases must be through an in-network Horizon Care @ Home provider. |
| | Hospice services | 10% coinsurance | Not covered | Deductible applies; Respite Day limits – 10. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Approved vision fees | Limited to one exam per calendar year. |
| | Children's glasses | $10 copay for lenses | Approved vision fees | Limited to one pair of glasses/frames or contact lenses per calendar year. |
| | Children's dental check-up | No charge | Approved dental fees | Out-of-network deductible applies. |

## 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
- Habilitation services
- Long-term care
- 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.)**

- Acupuncture (no coverage for pain management)
- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. Call 1-800-522-4161.
- Dental care ($2,500 annual maximum)
- Hearing aids ($350 maximum – once every five years; dependents not eligible)
- Infertility treatment ($5,000 lifetime maximum per family)
- Private-duty nursing ($7,000 annual maximum)
- Routine eye 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 Benefits Security Administration at 1-866-444-EBSA (3272) 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 the Plan at 1-800-522-4161. You may also contact the Department of Labor's 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 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 [1-800-522-4161].]

*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 | $250 |
| Specialist copayment | $30 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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 | $250 |
| Copayments | $60 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,470** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $30 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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* | $250 |
| Copayments | $600 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,110** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $30 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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* | $250 |
| Copayments | $90 |
| Coinsurance | $90 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$430** |

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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