
 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 (TTY: 711). 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 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Calendar year: \$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 and in-network dental and vision care 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 ?	Calendar year: \$2,500 individual (Medical - \$2,250 & prescription drug coverage - \$250)/\$5,000 family (\$4,500 & \$500)	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 (TTY: 711) 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 . You will pay the most if you use an out-of-network provider , and you might receive a network 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 anesthesia and 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% coinsurance	Not covered	Deductible applies.
	Specialist visit	20% coinsurance	Not covered	Deductible applies.
	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	Outpatient facility & inpatient or outpatient / out-of-hospital professional services for non-routine (diagnostic) x-ray /Radiology & Lab or Imaging – 20% 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/100 pills (retail); 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)	20% coinsurance	Not covered	Deductible applies; plan approval may be required for certain services.
	Physician/surgeon fees	20% coinsurance	Not covered	Deductible applies.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Deductible applies.
	Emergency medical transportation	20% coinsurance – Air & Ground Emergency services	20% coinsurance – Air & Ground Emergency services	Provided transportation services are medically necessary. Deductible applies.
	Urgent care	20% coinsurance	Not covered	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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Deductible applies. Preadmission & Concurrent Review apply.
	Physician/surgeon fees	20% coinsurance	Not covered	Deductible applies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Deductible applies. Contact Beacon Health Options (1-800-843-5503) to ensure that all services are covered.
	Inpatient services	20% coinsurance	Not covered	Deductible applies. Preauthorization required for inpatient services.
If you are pregnant	Office visits	20% coinsurance	Not covered	Deductible applies.
	Childbirth/delivery professional services	20% coinsurance	Not covered	Deductible applies.
	Childbirth/delivery facility services	20% 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	20% coinsurance	Not covered	Deductible applies; services limited to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance	Not covered	Deductible applies; services limited to 60 visits per calendar year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	Not covered	Deductible applies; maximum of 60 facility days per calendar year.
	Durable medical equipment	20% coinsurance	Not covered	Deductible applies. preauthorization required. All rentals or purchases must be through an in-network Horizon Care @ Home provider.
	Hospice services	20% 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 of 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](#).)

- Acupuncture
- Chiropractic care
- 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.)

- Bariatric surgery
- Coverage provided outside the United States. Call 1-800-522-4161(TTY: 711)
- Dental care (\$2,500 annual maximum)
- Hearing aids (\$350 maximum – once every five years)
- Infertility treatment (\$5,000 lifetime maximum)
- 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 (TTY: 711). 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 (TTY: 711)].]

—————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 coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$2,300
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,610

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 coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$400
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,310

Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$650