
 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](http://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 <a href="#">deductible</a> ?	Calendar year: \$250/Individual or \$500/Child(ren) (where eligible for dependent child coverage)	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , <a href="#">prescription drug coverage</a> , <a href="#">in-network</a> dental and vision care are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. Out-of-network Dental: \$15/individual or \$30/child(ren). No other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2,500 individual (Medical - \$2,250 & <a href="#">prescription drug coverage</a> - \$250)/\$5,000 child(ren) (\$4,500 & \$500)	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</a> , vision and dental charges, penalties for failure to obtain <a href="#">preauthorization</a> and health care 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> (call 1-800-355-BLUE [2583]) or call 1-800-522-4161 (TTY: 711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> and there is no coverage for <a href="#">out-of-network providers</a> in most instances. 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 network 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 anesthesia and lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

see a [specialist](#)?

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Covered up to allowance if no <a href="#">provider</a> within 50 miles.	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Age and frequency limits may apply.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (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% <a href="#">coinsurance</a> + <a href="#">deductible</a> .
	Imaging (CT/PET scans, MRIs)	No charge – Routine Imaging	Not covered	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$5 <a href="#">copay</a> /prescription (retail) & \$10 <a href="#">copay</a> /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 <a href="#">copay</a> /prescription (retail) & \$30 <a href="#">copay</a> /prescription (mail order)	Not covered	
	Non-preferred brand drugs	\$30 <a href="#">copay</a> /prescription (retail) & \$60 <a href="#">copay</a> /prescription (mail order)	Not covered	
	<a href="#">Specialty drugs</a>	\$5/\$15/\$30 <a href="#">copays</a> (retail)	Not covered	Covers up to a 34-day supply/100 pills. <a href="#">Preauthorization</a> is required.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> applies.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> – Air & Ground Emergency	20% <a href="#">coinsurance</a> – Air & Ground Emergency services	Provided transportation services are medically

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)	
		services		necessary. <a href="#">Deductible</a> applies.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. Contact Beacon Health Options (1-800-843-5503) to ensure that all services are covered.
	Inpatient services	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required for inpatient services.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies; 48 Hr. minimum – vaginal delivery; 96 Hr. minimum – caesarean section.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies; services limited to 100 visits per calendar year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies; services limited to 60 visits per calendar year. <a href="#">Preauthorization</a> is required.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies; maximum of 60 facility days per calendar year. <a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> required – all rentals or purchases must be through an <a href="#">in-network</a> Horizon Care @ Home provider.

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="#">Hospice services</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required. Limit of 10 days for Respite Care.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Approved vision fees	Limited to one exam per calendar year.
	Children's glasses	\$10 <a href="#">copay</a> 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 <a href="#">deductible</a> 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
- 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; [Preauthorization](#) is required.)
- Private-duty nursing (\$7,000 annual maximum; [Preauthorization](#) is required.)
- 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](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 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](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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
Deductibles	\$250
Copayments	\$10
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,520</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$770</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
Deductibles	\$250
Copayments	\$10
Coinsurance	\$500
What isn't covered	
Limits or exclusions	10
<b>The total Mia would pay is</b>	<b>\$760</b>