
 **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:
<b>What is the overall <a href="#">deductible</a>?</b>	Calendar year: <b>\$2,000</b> /Individual or <b>\$4,000</b> /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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , <a href="#">prescription drug coverage</a> , <a href="#">emergency room care</a> , <a href="#">in-network</a> dental and vision care (where eligible) are covered before you meet your calendar year <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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. Out-of-network Dental: \$15/individual or \$30 child(ren) (where eligible). There are no other specific calendar year <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.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$9,200</b> Individual (Medical - \$8,280 & <a href="#">prescription drug coverage</a> - \$920). <b>\$18,400</b> Child(ren) (where eligible) (Medical - \$16,560 & <a href="#">prescription drug coverage</a> - \$1,840).	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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 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 see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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 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="#">copay</a> /office visit	Not covered	<a href="#">Deductible</a> applies.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> / office visit (\$20 <a href="#">copay</a> /maternity visit)	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 preventive. 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	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.
<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)	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.

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 need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">copay</a> /visit (waived if admitted)	\$500 <a href="#">copay</a> /visit (waived if admitted)	No coverage for non-emergencies.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> + 30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	30% <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="#">copay</a> / office visit (other services + 30% <a href="#">coinsurance</a> )	Not covered	<a href="#">Deductible</a> applies. Contact Carelon Behavioral Health (1-800-843-5503) to ensure that all services are covered.
	Inpatient services	\$250 <a href="#">copay</a> + 30% <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="#">copay</a> /initial visit (to confirm pregnancy)	Not covered	<a href="#">Deductible</a> applies. No charge after 1 <sup>st</sup> visit.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies.
	Childbirth/delivery facility services	\$250 <a href="#">copay</a> + 30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$40 <a href="#">copay</a> /visit + 30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. Services limited to 60 visits per calendar year. (each visit – 2 hours / maximum of 16 hours per day). <a href="#">Preauthorization</a> is required.
	<a href="#">Rehabilitation services</a>	Inpatient facility: \$250 <a href="#">copay</a> + 30% <a href="#">coinsurance</a> Outpatient facility: 30% <a href="#">coinsurance</a> \$40 <a href="#">copay</a> / office visit (also applies for short term therapies)	Not covered	<a href="#">Deductible</a> applies. Limited to 90 days/visits for all therapies combined and for inpatient and outpatient services combined per calendar year. <a href="#">Preauthorization</a> is required.
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. Covered only if

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)	
				prior hospitalization and limited to 90 days per calendar year. <a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required. All rentals or purchases must be through an <a href="#">in-network</a> Horizon Care @ Home provider.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Deductible</a> applies. <a href="#">Preauthorization</a> is required. Limit 10 days for respite care.
If your child needs dental or eye care (where eligible)	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](#).)

- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 (limited to diagnoses for certain adult post-op dental pain, nausea & vomiting associated chemotherapy or pregnancy).
- Bariatric surgery (if medically necessary).
- Chiropractic care (Limited to 20 visits per calendar year for restorative care only.)
- Dental care (where service period for eligibility is met; \$2,500 annual maximum – member only).
- Routine eye care (where service period for eligibility is met).
- Nutritional Counseling (Limited to 3 visits per year).
- Physical & occupational therapy (Limited to 90 visits per year).

**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)].

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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](#) \$2,000
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 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*)

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

Cost Sharing	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$2,700
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,770</b>

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 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*)

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

Cost Sharing	
Deductibles	\$1,800
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,020</b>

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 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*)

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

Cost Sharing	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>