




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:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>Calendar year: <b>\$2,000</b>/Individual or <b>\$4,000</b>/Child(ren) (where eligible for dependent child coverage)</p>	<p>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>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>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>.</p>	<p>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>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. Out-of-network Dental: \$15/individual or \$30 child(ren) (where eligible). There are no other specific calendar year <a href="#">deductibles</a>.</p>	<p>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.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>\$10,600</b> Individual (Medical - \$9,540 &amp; <a href="#">prescription drug coverage</a> - \$1,060).  <b>\$21,200</b> Child(ren) (where eligible) (Medical - \$19,080 &amp; <a href="#">prescription drug coverage</a> - \$2,120).</p>	<p>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.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><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.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>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>.</p>	<p>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.</p>

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 Horizon Behavioral Health (1-800-626-2212) 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.
<b>If your child needs dental or eye care (where eligible)</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](#).)

- 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:**

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$2,700
<i>What isn't covered</i>	
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:**

<i>Cost Sharing</i>	
Deductibles	\$1,800
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
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:**

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