

 **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, visit [www.myisashealth.com](http://www.myisashealth.com). 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.myisashealth.com](http://www.myisashealth.com) or by calling 1-877-220-2514 to request a copy.

Important Questions	Answers			Why This Matters:
<b>What is the overall deductible?</b>		<b>Network</b>	<b>Non-Network</b>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
	<b>Per participant</b>	\$3,000	\$9,000	
	<b>Per family</b>	\$7,500	\$22,500	
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive care and any service listed below as No Charge.			This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.			You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>		<b>Network</b>	<b>Non-Network</b>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
	<b>Per participant</b>	\$4,100	Not Applicable	
	<b>Per family</b>	\$10,250	Not Applicable	
<b>What is not included in the out-of-pocket limit?</b>	Yes. Premiums, balance-billed charges, health care this plan doesn't cover, and penalties for failure to provide notification or obtain pre-authorization for services.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	<p><b>Yes, for medical:</b> Blue Cross Blue Shield PPO. For a list of preferred providers, call 1-877-220-2514 or visit <a href="http://provider.bcbs.com/">http://provider.bcbs.com/</a>.</p> <p><b>Yes, for prescription drugs:</b> Caremark. For a list of retail and mail pharmacies, log on to <a href="http://www.caremark.com">www.caremark.com</a>.</p>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	Your Cost if You Use a(n)		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Non-Network Provider	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	No Charge after deductible is met	50% co-insurance	Includes lab, x-ray, and diagnostic test performed in office.  <b>Chiropractic <u>Calendar Year Maximum</u>:</b> fifty-two (52) visits. After the first twenty-four (24) visits, the <u>Plan</u> will only cover <u>medically necessary</u> chiropractic services.
	<u>Specialist</u> visit	5% co-insurance	50% co-insurance	
	<u>Preventive care/screening/immunization</u>	No Charge	50% co-insurance	_____none_____
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	<b>Lab &amp; X-Ray Services:</b> No Charge after deductible is met  <b>Other Diagnostic Services:</b> 5% co-insurance	50% co-insurance	_____none_____
	Imaging (CT/PET scans, MRIs)	5% co-insurance	50% co-insurance	<b><u>Pre-certification</u> is required.</b> Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply.

\* For more information about limitations and exceptions, see the plan or policy document at [www.myisashealth.com](http://www.myisashealth.com).

Common Medical Event	Services You May Need	Your Cost if You Use a(n)		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Non-Network Provider	
<p><b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.caremark.com">www.caremark.com</a></p>	Generic drugs	<b>Retail Short-Term:</b> \$5 co-payment after deductible is met  <b>Retail Maintenance:</b> \$10 co-payment after deductible is met  <b>Mail Order:</b> \$10 co-payment after deductible is met	<b>Retail Short-Term:</b> \$5 co-payment after deductible is met  <b>Retail Maintenance:</b> \$10 co-payment after deductible is met  <b>Mail Order:</b> Not Covered	<p><b>Retail Short-Term:</b> 30 days, up to two (2) fills  <b>Retail Maintenance:</b> 30 days, after two (2) fills  <b>Mail Order:</b> 90 days</p> <p>Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u>, log into your account at <a href="http://www.caremark.com">www.caremark.com</a>.</p> <p>If you obtain <u>prescription drugs</u> from a <u>non-network</u> pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement. You will be responsible for the difference between the <u>in-network</u> allowed amount and the billed charge.</p> <p>When a generic drug is available, but the provider indicates a brand name drug is necessary or the member requests the brand name alternative, the Plan will cover the cost of the generic level only. The difference between the cost of the brand and generic will be the member's responsibility.</p>
	Preferred brand drugs	<b>Retail Short-Term:</b> \$20 co-payment after deductible is met  <b>Retail Maintenance:</b> \$30 co-payment after deductible is met  <b>Mail Order:</b> \$50 co-payment after deductible is met	<b>Retail Short-Term:</b> \$20 co-payment after deductible is met  <b>Retail Maintenance:</b> \$30 co-payment after deductible is met  <b>Mail Order:</b> Not Covered	
	Non-preferred brand drugs	<b>Retail Short-Term:</b> \$40 co-payment after deductible is met  <b>Retail Maintenance:</b> \$60 co-payment after deductible is met  <b>Mail Order:</b> \$100 co-payment after deductible is met	<b>Retail Short-Term:</b> \$40 co-payment after deductible is met  <b>Retail Maintenance:</b> \$60 co-payment after deductible is met  <b>Mail Order:</b> Not Covered	
	<u>Specialty drugs</u>	<b>Generic and Preferred Brand Drugs:</b> 5% co-insurance  <b>Non-Preferred Brand Drugs:</b> 10% co-insurance	Not Covered	

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Common Medical Event	Services You May Need	Your Cost if You Use a(n)		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Non-Network Provider	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	5% co-insurance	Not Covered	If you use the SurgeryPlus option, services will be covered at no charge after <u>deductible</u> is met. <b>Pre-certification is required.</b> Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply.
	Physician/surgeon fees	5% co-insurance	50% co-insurance	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	5% co-insurance	5% co-insurance	—————none—————
	<u>Emergency medical transportation</u>	5% co-insurance	5% co-insurance	Emergency transportation is available by ground, air, or water to the closest hospital that offers appropriate emergency care.
	<u>Urgent care</u>	5% co-insurance	50% co-insurance	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	5% co-insurance	Not Covered	If you use the SurgeryPlus option, services will be covered at no charge after <u>deductible</u> is met. <b>Pre-certification is required.</b> Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply.
	Physician/surgeon fees	5% co-insurance	50% co-insurance	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No Charge after deductible is met	50% co-insurance	—————none—————
	Inpatient services	5% co-insurance	50% co-insurance	<b>Pre-certification is required.</b> Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply.
<b>If you are pregnant</b>	Office visits	No Charge after deductible is met for initial office visit only	50% co-insurance	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>co-insurance</u> or <u>deductible</u> may apply.
	Childbirth/delivery professional services	5% co-insurance	50% co-insurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	5% co-insurance	Not Covered	<b>Pre-certification is required</b> for <u>in-patient</u> stay over forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for caesarian delivery. Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special needs</b>	<u>Home health care</u>	5% co-insurance	50% co-insurance	<b>Pre-certification is required.</b> Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply. <b>Calendar Year Maximum:</b> one hundred twenty (120) visits.
	<u>Rehabilitation services</u>	5% co-insurance	50% co-insurance	Must be goal-directed rehabilitation. <b>Pre-certification is required.</b> Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply.
	<u>Habilitation services</u>	5% co-insurance	50% co-insurance	Must be goal-directed habilitation. <b>Pre-certification is required.</b> Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply.
	<u>Skilled nursing care</u>	5% co-insurance	50% co-insurance	<b>Pre-certification is required.</b> Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply. <b>Calendar Year Maximum:</b> one hundred (100) visits.
	<u>Durable medical equipment</u>	5% co-insurance	50% co-insurance	<b>Pre-certification is required</b> on equipment over \$1,500. Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply.
	<u>Hospice services</u>	No Charge after deductible is met	50% co-insurance	<b>Pre-certification is required.</b> Penalty of \$250 <u>in-network</u> or \$750 <u>out-of-network</u> will apply.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	Vision coverage is a separate election.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Dental coverage is a separate election.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.myisashealth.com](http://www.myisashealth.com).

## 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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Private-duty nursing
- Weight loss programs (Naturally Slim for metabolic syndrome)

**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). You may also contact the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise, ID 83707, 1-800-920-7237. 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: 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). You may also contact the Care Coordinator to assist the plan administrator. The Care Coordinator's name, address, and telephone number are:

Quantum Health Inc.  
Attention: Appeals  
5240 Blazer Way  
Dublin, OH 43017  
1-877-225-2981

### 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 the 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 1-877-225-2981.

\* For more information about limitations and exceptions, see the plan or policy document at [www.myisashealth.com](http://www.myisashealth.com).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-225-2981.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-225-2981.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-225-2981.

*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)

■ <u>The plan's overall deductible</u>	\$3,000
■ <u>Specialist cost sharing</u>	5%
■ <u>Hospital (facility) cost sharing</u>	5%
■ <u>Other cost sharing</u>	5%

#### 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	\$3,000
Copayments	\$0
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$4,120</b>

### Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$3,000
■ <u>Specialist cost sharing</u>	5%
■ <u>Hospital (facility) cost sharing</u>	5%
■ <u>Other cost sharing</u>	5%

#### 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	\$2,300
Copayments	\$70
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,370</b>

### Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$3,000
■ <u>Specialist cost sharing</u>	5%
■ <u>Hospital (facility) cost sharing</u>	5%
■ <u>Other cost sharing</u>	5%

#### 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	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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