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. 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 or by calling 1-877-220-2514 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		**Network**	**Non-Network**	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.
	Per participant	$1,250	$4,000	
	Per family	$3,125	$10,000	
Are there services covered before you meet your deductible?	Yes. Preventive care, services that require co-payments, and services listed below as No Charge.			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?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?		**Network**	**Non-Network**	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.
	Per participant	$6,750	Not Applicable	
	Per family	$13,500	Not Applicable	

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	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 out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes, for medical:** Blue Cross Blue Shield PPO. For a list of preferred providers, call 1-877-220-2514 or visit http://provider.bcbs.com/. **Yes, for prescription drugs:** Caremark. For a list of retail and mail pharmacies, log on to www.caremark.com.	This plan uses a provider network. 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 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 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	Your Cost if You Use a(n)		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-payment/visit, deductible does not apply	50% co-insurance	Includes lab, x-ray, and diagnostic test performed in office. **Chiropractic Calendar Year Maximum:** fifty-two (52) visits. After the first twenty-four (24) visits, the Plan will only cover medically necessary chiropractic services.
	Specialist visit	$40 co-payment/visit, deductible does not apply	50% co-insurance	
	Preventive care/screening/ immunization	No Charge	50% co-insurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	**Lab and X-Ray Services:** $20 co-payment, deductible does not apply **Other Diagnostic Tests:** 15% co-insurance	50% co-insurance	Lab, x-ray, and diagnostic tests performed in the office will be covered under the office visit benefit.
	Imaging (CT/PET scans, MRIs)	15% co-insurance	50% co-insurance	**Pre-certification is required**. Penalty of $250 in-network or $750 out-of-network will apply.

* For more information about limitations and exceptions, see the plan or policy document at 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	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	**Retail Short-Term:** $10 co-payment, deductible does not apply **Retail Maintenance:** $15 co-payment, deductible does not apply **Mail Order:** $25 co-payment, deductible does not apply	**Retail Short-Term:** $10 co-payment, deductible does not apply **Retail Maintenance:** $15 co-payment, deductible does not apply **Mail Order:** Not Covered	**Retail Short-Term:** 30 days, up to two (2) fills **Retail Maintenance:** 30 days, after two (2) fills **Mail Order:** 90 days Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.caremark.com. If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement. You will be responsible for the applicable co-payment plus the difference between the in-network allowed amount and the billed charge. 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.
	Preferred brand drugs	**Retail Short-Term:** $30 co-payment, deductible does not apply **Retail Maintenance:** $40 co-payment, deductible does not apply **Mail Order:** $75 co-payment, deductible does not apply	**Retail Short-Term:** $30 co-payment, deductible does not apply **Retail Maintenance:** $40 co-payment, deductible does not apply **Mail Order:** Not Covered	
	Non-preferred brand drugs	**Retail Short-Term:** $60 co-payment, deductible does not apply **Retail Maintenance:** $80 co-payment, deductible does not apply **Mail Order:** $150 co-payment, deductible does not apply	**Retail Short-Term:** $60 co-payment, deductible does not apply **Retail Maintenance:** $80 co-payment, deductible does not apply **Mail Order:** Not Covered	
	Specialty drugs	**Generic and Preferred Brand Drugs:** 10% co-insurance **Non-Preferred Brand Drugs:** 15% co-insurance	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at 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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% co-insurance	Not Covered	If you use the SurgeryPlus option, services will be covered at no charge after deductible is met. **Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
	Physician/surgeon fees	15% co-insurance	50% co-insurance	
If you need immediate medical attention	Emergency room care	$200 co-payment/visit, deductible does not apply	$200 co-payment per visit, deductible does not apply	Co-payment is waived if the patient is admitted into the hospital.
	Emergency medical transportation	$75 co-payment/ transport, deductible does not apply	$75 co-payment/ transport, deductible does not apply	Emergency transportation is available by ground, air, or water to the closest hospital that offers appropriate emergency care.
	Urgent care	$75 co-payment/visit, deductible does not apply	50% co-insurance	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	15% co-insurance	Not Covered	If you use the SurgeryPlus option, services will be covered at no charge after deductible is met. **Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
	Physician/surgeon fees	15% co-insurance	50% co-insurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 co-payment/visit, deductible does not apply	50% co-insurance	——————————none——————————
	Inpatient services	15% co-insurance	50% co-insurance	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
If you are pregnant	Office visits	$20 co-payment, deductible does not apply, for initial office visit only	50% co-insurance	Cost sharing does not apply for preventive services. Depending on the type of services, co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). **Pre-certification is required** for in-patient stay over forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for caesarian delivery. Penalty of $250 in-network or $750 out-of-network will apply.
	Childbirth/delivery professional services	15% co-insurance	50% co-insurance	
	Childbirth/delivery facility services	15% co-insurance	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at 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	
If you need help recovering or have other special needs	Home health care	15% co-insurance	50% co-insurance	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply. **Calendar Year Maximum:** one hundred twenty (120) visits.
	Rehabilitation services	**Physical Therapy:** $40 co-payment/visit, deductible does not apply **Occupational Therapy and Speech Therapy:** 15% co-insurance	50% co-insurance	Must be goal-directed rehabilitation. **Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
	Habilitation services	**Physical Therapy:** $40 co-payment/visit, deductible does not apply **Occupational Therapy and Speech Therapy:** 15% co-insurance	50% co-insurance	Must be goal-directed habilitation. **Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
	Skilled nursing care	15% co-insurance	50% co-insurance	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply. **Calendar Year Maximum:** one hundred 100 visits.
	Durable medical equipment	15% co-insurance	50% co-insurance	**Pre-certification is required** on equipment over $1,500. Penalty of $250 in-network or $750 out-of-network will apply.
	Hospice services	No Charge after deductible is met	50% co-insurance	**Pre-certification is required.** Penalty of $250 in-network or $750 out-of-network will apply.
If your child needs dental or eye care	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.

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. 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 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.
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.

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, kwiijigo 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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* For more information about limitations and exceptions, see the plan or policy document at www.myisashealth.com.

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	$1,250
Specialist copayment	$40
Hospital (facility) cost sharing	15%
Other cost sharing	15%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$100
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,870**

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

The plan's overall deductible	$1,250
Specialist copayment	$40
Hospital (facility) cost sharing	15%
Other cost sharing	15%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

The plan's overall deductible	$1,250
Specialist copayment	$40
Hospital (facility) cost sharing	15%
Other cost sharing	15%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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