
 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 1-855-258-6459 or visit the LiveTotal Health page on the Garden (or livetotalhealth.com) and click on the Quantum Health button. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary on the Quantum Health portal or call 1-855-258-6459 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall <u>deductible</u> ?		<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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
	Per participant:	\$1,750	\$4,500	
	Per family:	\$3,500	\$9,000	
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Network</u> preventive care services.			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> .
Are there other <u>deductibles</u> for specific services?	No.			You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?		<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.
	Per participant:	\$6,000	\$12,000	
	Per family:	\$12,000	\$24,000	
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and non-medically necessary services.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	<b>Yes:</b> Anthem. See www.anthem.com or call 1-855-258-6459 for a list of network providers.			This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's</u> 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 <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	<b>No.</b>	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	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 visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	<u>Specialist</u> visit	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	<u>Preventive care/screening/immunization</u>	No charge, deductible waived	40% co-insurance after deductible	<b>Calendar Year Maximum:</b> one (1) adult visit. This limit does not apply to the well-woman visit. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>

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

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 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>	Generic drugs	<b>Retail:</b> 20% co-insurance after deductible Minimum: \$4 Maximum: \$15  <b>Retail-90/Mail Order:</b> 20% co-insurance after deductible Minimum: \$10 Maximum: \$35	Not covered	Retail: Up to thirty (30) day supply; up to eighty-four (84) days' supply for maintenance drugs.  Mail Order: Eighty-four (84) to ninety (90) day supply.  Preventive prescription drugs are not subject to the deductible.  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> .
	Preferred brand drugs	<b>Retail:</b> 20% co-insurance after deductible Minimum: \$20 Maximum: \$50  <b>Retail-90/Mail Order:</b> 20% co-insurance after deductible Minimum: \$50 Maximum: \$125		
	Non-preferred brand drugs	<b>Retail:</b> 20% co-insurance after deductible Minimum: \$40 Maximum: \$80  <b>Retail-90/Mail Order:</b> 20% co-insurance after deductible Minimum: \$100 Maximum: \$200		
	<u>Specialty drugs</u>	Benefits will be based on drug classification listed above	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>

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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)	
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% co-insurance after deductible	20% co-insurance after deductible	_____none_____
	<u>Emergency medical transportation</u>	20% co-insurance after deductible	20% co-insurance after deductible	_____none_____
	<u>Urgent care</u>	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required for partial hospitalization and intensive outpatient treatment.</b>
	Inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
<b>If you are pregnant</b>	Office visits	20% co-insurance after deductible	40% co-insurance after deductible	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% co-insurance after deductible	40% co-insurance after deductible	Depending on the type of services, a co-payment, co-insurance, or deductible may apply.
	Childbirth/delivery facility services	20% co-insurance after deductible	40% co-insurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
<b>If you need help recovering or have other special needs</b>	<u>Home health care</u>	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
	<u>Rehabilitation services</u>	20% co-insurance after deductible	40% co-insurance after deductible	<b>Calendar Year Maximum:</b> sixty (60) visits for occupation and physical therapy combined; twenty-five (25) visits for speech therapy.
	<u>Habilitation services</u>	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	<u>Skilled nursing care</u>	20% co-insurance after deductible	40% co-insurance after deductible	<b>Calendar Year Maximum:</b> one hundred (100) days per plan participant.

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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>Pre-certification is required.</b>
	<u>Durable medical equipment</u>	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required for DME rentals and purchases over \$1,500.</b>
	<u>Hospice services</u>	20% co-insurance after deductible	40% co-insurance after deductible	<b>Pre-certification is required.</b>
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge after deductible	40% co-insurance after deductible	<b>Calendar Year Maximum: one (1) per plan participant.</b>
	Children's glasses	Not covered	Not covered	_____none_____
	Children's dental check-up	Not covered	Not covered	_____none_____

### 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.)

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|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Acupuncture (except when used in lieu of anesthetic)</li> <li>Cosmetic surgery</li> </ul> | <ul style="list-style-type: none"> <li>Dental care</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |
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#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Bariatric surgery – pre-certification required</li> <li>Chiropractic care [Calendar Year Maximum: twenty (20) visits]</li> </ul> | <ul style="list-style-type: none"> <li>Hearing aids (Lifetime maximum: \$5,000)</li> <li>Infertility treatment (Lifetime maximum: \$20,000 for medical, \$10,000 for prescription drugs)</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care</li> </ul> |
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**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 Scotts Benefit Service Center, P.O. Box 5295, Cherry Hill, NJ 08034-5295. 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 Plan Administrator for appeals information. The Plan Administrator's name, address, and telephone number are:

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The Scotts Company LLC  
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1-855-258-6459

**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 1-855-258-6459.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6459.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-258-6459.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-258-6459.

*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 \$1,750
- Specialist cost sharing 20%
- Hospital (facility) cost sharing 20%
- Other cost sharing 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:**

<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$3,870</b>

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

- The plan's overall deductible \$1,750
- Specialist cost sharing 20%
- Hospital (facility) cost sharing 20%
- Other cost sharing 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:**

<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,550</b>

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

- The plan's overall deductible \$1,750
- Specialist cost sharing 20%
- Hospital (facility) cost sharing 20%
- Other cost sharing 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:**

<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,550</b>

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