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.MyAmeriBen.com or call 1-855-258-2658. 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.MyAmeriBen.com or call 1-855-258-2658 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:	$1,000	$3,000	
	Per family:	$2,000	$6,000	
Are there services covered before you meet your deductible?	Yes. Office visits, speech/physical/occupational therapies, true emergency care, retail clinics, home visits, podiatry services, mandated prenatal/postnatal care, preventive care, and some prescription drugs.			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	$12,000	
	Per family:	$13,500	$24,000	
What is not included in the out-of-pocket limit?	Premiums, penalties, amounts over usual fees, and charges this Plan does not cover.			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: Anthem.** For a list of preferred providers, call Anthem, at 1-800-810-BLUE or visit **www.anthem.com**. **Yes, for prescription drugs: Magellan Rx.** For a list of retail and mail pharmacies, log on to **www.magellanrx.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.

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-payment/per provider	40% co-insurance, after deductible	The office visit co-payment will apply to all services performed in the office setting, except for: chemotherapy, radiation therapy, diagnostic testing/advanced imaging, and surgery. The following providers are considered PCPs: Internal Medicine, Family/General Practitioner, OB/GYN, Pediatricians, Behavioral Health Practitioners, Nurse Practitioners, and Physician Assistants. Home Visits are covered. **Pre-certification is required** for some in-office services, such as chemo/radiation therapy and advanced imaging. Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.
	Specialist visit	$60 co-payment/per provider	40% co-insurance, after deductible	
	Preventive care/screening/ immunization	No Charge	40% co-insurance, after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (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	**Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.

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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.magellanrx.com**	Generic drugs	**1-30 day supply**: $15 co-payment **31-90 day supply**: $37.50 co-payment	Not Covered	**Retail and Mail Order**: Limited to ninety (90) day supply. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at **www.magellanrx.com**. If you obtain prescription drugs from a non-network pharmacy, or obtain prescription drugs from a network pharmacy when the identification card is not used, you will be required to pay the full cost of the prescription. **Pre-certification is required** for prescription drugs in excess of $15,000. Specialty drugs can be filled one (1) time at retail, then mail order is required. **Also includes cost difference between name brand and generic forms, unless prescription drug is not manufactured in generic form or physician has indicated "dispense as written" or similar indication. Penalty does not apply to the out-of-pocket limit.
	Preferred brand drugs**	**1-30 day supply**: $35 co-payment **31-90 day supply**: $87.50 co-payment	Not Covered	
	Non-preferred brand drugs**	**1-30 day supply**: $55 co-payment **31-90 day supply**: $137.50 co-payment	Not Covered	
	Specialty drugs	**30-day supply only**: 25% co-insurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance, after deductible	40% co-insurance, after deductible	**Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.
	Physician/surgeon fees	20% co-insurance, after deductible	40% co-insurance, after deductible	——————————none——————————
If you need immediate medical attention	Emergency room care	**True Emergency**: $250 co-payment, then 20% co-insurance after deductible	**True Emergency**: $250 co-payment, then 20% co-insurance after network deductible	The true emergency room co-payment will be waived if the patient is admitted to the hospital.

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)	
		Non-True Emergency: $250 co-payment, then 20% co-insurance after deductible	**Non-True Emergency**: $250 co-payment, then 40% co-insurance after deductible	
	Emergency medical transportation	20% co-insurance, after deductible	20% co-insurance, after network deductible	Covered charges include: ground, air, and water ambulance. Charges for medically necessary inter-facility transportation to the nearest accredited general hospital with adequate facility for treatment is covered. Chartered air ambulance is not covered. **Pre-certification is required for non-emergent ambulance.** Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.
	Urgent care	$100 co-payment/per provider	40% co-insurance, after deductible	Co-payment will apply to all services performed in the urgent care setting, except for: chemotherapy, radiation therapy, diagnostic testing/imaging and surgery. Retail clinics are covered at $75 copayment.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance, after deductible	40% co-insurance, after deductible	**Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.
	Physician/surgeon fees	20% co-insurance, after deductible	40% co-insurance, after deductible	——————————none——————————

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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visits:** $25 co-payment/per provider **All Other Services:** 20% co-insurance after deductible	40% co-insurance, after deductible	**Pre-certification is required for** outpatient Intensive Psychiatric Day Treatment, Partial Hospitalization, and Residential Treatment Facility. Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.
	Inpatient services	20% co-insurance, after deductible	40% co-insurance, after deductible	**Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.
If you are pregnant	Office visits	**Initial Office Visit**: $25 co-payment **All Other Services**: 20% co-insurance, after deductible	40% co-insurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Home births are not covered.
	Childbirth/delivery professional services	20% co-insurance after deductible	40% co-insurance after deductible	
	Childbirth/delivery facility services	20% co-insurance after deductible	40% co-insurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	**Pre-certification is required** for certain services within this category. Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity. **Calendar Year Maximum:** One-hundred twenty (120) visits. Four hours or less of non-custodial Health Aide services equals one Home Health Care visit. Rehabilitation therapy services rendered in the home will apply to the therapy maximum. Therapy services administered in the home as part of a home health care plan will apply to

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)	
				the home health care maximum.
	Rehabilitation services	**Outpatient Therapies**: $60 copayment/per provider **Other Services**: 20% co-insurance after deductible	40% co-insurance after deductible	**Calendar Year Maximum:** Combined sixty (60) visits for speech, physical, and occupational therapies. Inpatient rehabilitation services maximum is combined with skilled nursing. **Pre-certification is required for Inpatient Admissions.** Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.
	Habilitation services			
	Skilled nursing care	20% co-insurance after deductible	40% co-insurance after deductible	**Calendar Year Maximum:** Ninety (90) days. This maximum is combined with inpatient rehabilitation services. **Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	**Pre-certification is required** when the purchase price is expected to exceed $1,000**.** Failure to obtain pre-certification will result in a denial of benefits or may incur a 40% penalty after retroactive review of services proves medical necessity.
	Hospice services	20% co-insurance after deductible	40% co-insurance after deductible	**Pre-certification is required.** Failure to obtain Respite Care is covered.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	——————none——————
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (adult)
- Hearing Aids
- Infertility Treatment (testing is covered)
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (adult)
- Routine Foot Care (except due to metabolic or peripheral-vascular disease, or plantar fasciitis)
- 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 twenty (20) visits combined with chiropractic care)
- Chiropractic Care (limited to twenty (20) visits combined with acupuncture)

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. Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise, ID 83707, 1-888-888-8888. 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 third party administrator (TPA) to assist the plan administrator with claims adjudication. The TPA's name, address, and telephone number are:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-866-504-6814

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-855-258-2658.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-2658.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-258-2658
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-2658.

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

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	$60
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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$40
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,550**

This coverage example assumes the baby is enrolled in the Plan.

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

The plan's overall deductible	$1,000
Specialist copayment	$60
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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$2,000**

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

The plan's overall deductible	$1,000
Specialist copayment	$60
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*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,630**

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