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 1-888-235-0228 or visit www.MyAmeriBen.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.MyAmeriBen.com or call 1-888-235-0228 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:	$3,000	$5,500	
	Per family:	$6,000	$11,000	
Are there services covered before you meet your deductible?	**Yes.** Network preventive care.			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:	$3,000	$11,000	
	Per family:	$6,000	$22,000	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan 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 out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes, for medical:** Anthem. See www.anthem.com or call 1-888-235-0228 for a list of network providers. **Yes, for prescription drugs:** TrueScripts. For a list of retail and mail pharmacies, log on to			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

	www.truescripts.com or call 1-844-257-1955.	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	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	No charge after deductible	30% co-insurance after deductible	——————————none——————————
	Specialist visit	No charge after deductible	30% co-insurance after deductible	
	Preventive care/screening/ immunization	No charge, deductible waived	Not covered	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)	No charge after deductible	30% co-insurance after deductible	**Pre-certification is required for certain services.** Failure to obtain pre-certification may reduce benefits by 50%.
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% co-insurance after deductible	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by 50%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truescripts.com	Generic drugs	No charge after deductible	Not covered	Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.truescripts.com. Specialty drugs are limited to a thirty (30) day supply and require pre-certification. The specialty drug formulary changes from time to time. To see if your prescription is covered under the plan, as well as the level of coverage, please contact TrueScripts at 1-844-257-1955.
	Preferred brand drugs	No charge after deductible		
	Non-preferred brand drugs	No charge after deductible		
	Specialty drugs	**Tier 1:** No charge after deductible **Tier 2:** 20% co-insurance after deductible up to $550.00 maximum **Tier 3:** 20% co-insurance after		

* 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)	
		deductible up to $2,000.00 maximum **Tier 4:** 20% co-insurance after deductible **Tier 5:** 50% co-insurance deductible		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% co-insurance after deductible	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by 50%.
	Physician/surgeon fees	No charge after deductible	30% co-insurance after deductible	——————————none——————————
If you need immediate medical attention	Emergency room care	No charge after deductible	No charge after deductible	——————————none——————————
	Emergency medical transportation	No charge after deductible	No charge after deductible	——————————none——————————
	Urgent care	No charge after deductible	30% co-insurance after deductible	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% co-insurance after deductible	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by 50%.
	Physician/surgeon fees	No charge after deductible	30% co-insurance after deductible	——————————none——————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	30% co-insurance after deductible	**Pre-certification is required for intensive outpatient services and partial hospitalization.** Failure to obtain pre-certification may reduce benefits by 50%.
	Inpatient services	No charge after deductible	30% co-insurance after deductible	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by 50%.
If you are pregnant	Office visits	No charge, deductible waived	30% co-insurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, co-insurance or deductible may apply. Maternity care may include tests and services
	Childbirth/delivery professional services	No charge after deductible	30% co-insurance after deductible	
	Childbirth/delivery facility services	No charge after deductible	30% co-insurance after deductible	

* 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)	
				described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special needs	Home health care	No charge after deductible	30% co-insurance after deductible	**Calendar Year Maximum:** Sixty (60) visits per plan participant. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by 50%.
	Rehabilitation services	No charge after deductible	30% co-insurance after deductible	**Pre-certification is required for certain services.** Failure to obtain pre-certification may reduce benefits by 50%.
	Habilitation services	No charge after deductible	30% co-insurance after deductible	
	Skilled nursing care	No charge after deductible	30% co-insurance after deductible	**Calendar Year Maximum:** Sixty (60) days per plan participant. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by 50%.
	Durable medical equipment	No charge after deductible	30% co-insurance after deductible	**Pre-certification is required for DME in excess of $1,000.** Failure to obtain pre-certification may reduce benefits by 50%.
	Hospice services	No charge after deductible	30% co-insurance after deductible	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by 50%.
If your child needs dental or eye care	Children's eye exam	No charge after deductible	Not covered	——————————none——————————
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when travelling 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.)

- Chiropractic care
- Hearing aids
- Routine eye care

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

Your Rights to Continue Coverage: 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 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
1-888-235-0228

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 1-888-235-0228.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-235-0228.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-888-235-0228.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-235-0228.

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

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.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	$3,000
Specialist cost sharing	0%
Hospital (facility) cost sharing	0%
Other cost sharing	0%

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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,020**

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

The plan's overall deductible	$3,000
Specialist cost sharing	0%
Hospital (facility) cost sharing	0%
Other cost sharing	0%

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	$2,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,300**

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

The plan's overall deductible	$3,000
Specialist cost sharing	0%
Hospital (facility) cost sharing	0%
Other cost sharing	0%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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