




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 <u>deductible</u> ?		Network	Non-Network	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> .
	Per participant:	\$1,500	\$2,000	
	Per family:	\$1,750	\$4,000	
Are there services covered before you meet your <u>deductible</u> ?	Yes. Network preventive care, prescription drugs, office visits, and services which require a co-payment.			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 preventive services without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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> ?		Network	Non-Network	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:	\$3,250	\$6,000	
	Per family:	\$6,500	\$12,000	
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> ?	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 <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

	www.truescripts.com or call 1-844-257-1955.	work). Check with your <u>provider</u> 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	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, deductible waived	30% co-insurance after deductible	<u>Co-payment</u> is applied per visit. <u>Co-payment</u> applies to office visit charge only. Services received in conjunction with an urgent care visit may require additional <u>co-payments</u> , <u>deductibles</u> , or <u>co-insurance</u> . 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.
	<u>Specialist</u> visit	\$50 co-payment, deductible waived	30% co-insurance after deductible	
	<u>Preventive care/screening/immunization</u>	No charge, deductible waived	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge, deductible waived	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)	20% co-insurance 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 <u>prescription drug coverage</u> is available at www.truescripts.com	Generic drugs	1-30 Day Supply: \$10 co-payment 31-90 Day Supply: \$25 co-payment	Not covered	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 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	1-30 Day Supply: \$35 co-payment 31-90 Day Supply: \$88 co-payment		
	Non-preferred brand drugs	1-30 Day Supply: \$60 co-payment 31-90 Day Supply: \$150 co-payment		
	<u>Specialty drugs</u>	Tier 1: 25% co-insurance up to		

* 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)	
		\$150.00 maximum Tier 2: 20% co-insurance up to \$550.00 maximum Tier 3: 20% co-insurance up to \$2,000.00 maximum Tier 4: 20% co-insurance Tier 5: 50% co-insurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	30% co-insurance after deductible	Pre-certification is required. Failure to obtain pre-certification may reduce benefits by 50%.
	Physician/surgeon fees	20% co-insurance after deductible	30% co-insurance after deductible	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	\$150 co-payment, deductible waived	\$150 co-payment, deductible waived	<u>Co-payment</u> is applied per visit.
	<u>Emergency medical transportation</u>	20% co-insurance after deductible	20% co-insurance after network deductible	_____none_____
	<u>Urgent care</u>	\$50 co-payment, deductible waived	30% co-insurance after deductible	<u>Co-payment</u> is applied per visit. <u>Co-payment</u> applies to urgent care visit only. Services received in conjunction with an urgent care visit may require additional <u>co-payments</u> , <u>deductibles</u> , or <u>co-insurance</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	30% co-insurance after deductible	Pre-certification is required. Failure to obtain pre-certification may reduce benefits by 50%.
	Physician/surgeon fees	20% co-insurance after deductible	30% co-insurance after deductible	_____none_____

* 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 need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$25 co-payment, deductible waived Outpatient Services: 20% co-insurance 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	20% co-insurance 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.
	Childbirth/delivery professional services	20% co-insurance after deductible	30% 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	30% co-insurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special needs	<u>Home health care</u>	20% co-insurance 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%.
	<u>Rehabilitation services</u>	\$25 co-payment, deductible waived	30% co-insurance after deductible	Pre-certification is required for certain services. Failure to obtain pre-certification may reduce benefits by 50%.
	<u>Habilitation services</u>	\$25 co-payment, deductible waived	30% co-insurance after deductible	
	<u>Skilled nursing care</u>	20% co-insurance 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%.
	<u>Durable medical equipment</u>	20% co-insurance 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%.
	<u>Hospice services</u>	20% co-insurance after deductible	30% co-insurance after deductible	Pre-certification is required. Failure to obtain pre-certification may reduce benefits by 50%.

* 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 your child needs dental or eye care	Children's eye exam	\$25 co-payment, deductible waived	Not covered	<u>Co-payment</u> is applied per visit.
	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.)

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when travelling outside - the U.S. | <ul style="list-style-type: none"> • 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.)

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|---------------------|----------------|--------------------|
| • Chiropractic care | • Hearing aids | • Routine eye care |
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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. 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

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

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, kwijigo holne' 1-888-235-0228.

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.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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> co-payment	\$25
■ Hospital (facility) <u>cost sharing</u>	20%
■ Other <u>cost sharing</u>	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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$3,220

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> co-payment	\$25
■ Hospital (facility) <u>cost sharing</u>	20%
■ Other <u>cost sharing</u>	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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$600
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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> co-payment	\$25
■ Hospital (facility) <u>cost sharing</u>	20%
■ Other <u>cost sharing</u>	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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,850

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