
 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 1-844-209-0080. 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 1-844-209-0080 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:	\$3,200	\$6,000	
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> .			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 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:	\$5,000	\$15,000	
	Per family:	\$10,000	\$30,000	
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, and non-medically necessary services.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	<p>Yes, for medical: Anthem. See www.anthem.com or call 1-800-331-1476 for a list of <u>network providers</u>.</p> <p>Yes, for prescription drugs: MaxorPlus. For a list of retail and mail pharmacies, log on to www.maxor.com or call 1-800-687-0707. For <u>specialty drugs</u>, call MaxorPlus Specialty at 1-866-629-6779.</p>	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.
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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% co-insurance after deductible	40% co-insurance after deductible	Retail clinics and home visits are also covered.
	<u>Specialist</u> visit	20% co-insurance after deductible	40% co-insurance after deductible	
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	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.
If you have a test	<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	_____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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.maxor.com .	Generic drugs	20% co-insurance after deductible, up to \$200	Not Covered	Retail Day Supply Limit: thirty-four (34) day supply Specialty Drugs are limited to a thirty (30) day supply for retail purchases. Mail Order Supply Limit: ninety (90) day supply Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your plan, log into your account at www.maxor.com . If you obtain <u>prescription drugs</u> from a non-network pharmacy, you will be required to pay the full cost of the prescription. Pre-certification is required for some drugs.
	Preferred brand drugs	20% co-insurance after deductible, up to \$200	Not Covered	
	Non-preferred brand drugs	20% co-insurance after deductible, up to \$200	Not Covered	
	<u>Specialty drugs</u>	20% co-insurance after deductible, up to \$200	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 [except for office surgeries, all colonoscopies and sigmoidoscopies (screening and diagnostic), and intra-articular hyaluronic acid injections].
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need immediate medical attention	<u>Emergency room care</u>	20% co-insurance after deductible		_____none_____
	<u>Emergency medical transportation</u>	20% co-insurance after deductible		Pre-certification is required for non-emergent air ambulance. Chartered air flights are not covered.
	<u>Urgent care</u>	20% co-insurance after deductible	40% 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 have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	<u>Pre-certification</u> is required.
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	<u>Pre-certification</u> is required for partial hospitalization and intensive outpatient programs in excess of eighteen (18) visits per calendar year.
	Inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	<u>Pre-certification</u> is required.
If you are pregnant	Office visits	20% co-insurance after deductible	40% co-insurance after deductible	<u>Cost sharing</u> does not apply for <u>preventive</u> services.
	Childbirth/delivery professional services	20% co-insurance after deductible	40% co-insurance after deductible	Depending on the type of services, a <u>co-payment</u> , <u>co-insurance</u> , or <u>deductible</u> 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).
If you need help recovering or have other special needs	<u>Home health care</u>	20% co-insurance after deductible	40% co-insurance after deductible	<u>Pre-certification</u> is required.
	<u>Rehabilitation services</u>	20% co-insurance after deductible	40% co-insurance after deductible	Calendar Year Limit: sixty (60) visits for physical, occupational, and speech therapy combined <u>Pre-certification</u> is required after the calendar year limit has been met.

* 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 help recovering or have other special needs	<u>Habilitation services</u>	20% co-insurance after deductible	40% co-insurance after deductible	Maintenance therapy is not covered. Calendar Year Limit: sixty (60) visits for physical, occupational, and speech therapy combined Pre-certification is required after the calendar year limit has been met.
	<u>Skilled nursing care</u>	20% co-insurance after deductible	40% co-insurance after deductible	Calendar Year Limit: one hundred twenty (120) days Pre-certification is required.
	<u>Durable medical equipment</u>	20% co-insurance after deductible	40% co-insurance after deductible	Pre-certification is required for <u>durable medical equipment</u> in excess of \$2,000 (purchase price only).
	<u>Hospice services</u>	20% co-insurance after deductible	40% co-insurance after deductible	Respite care is not covered.
If your child needs dental or eye care	Children's eye exam	Not Covered		_____none_____
	Children's glasses	Not Covered		
	Children's dental check-up	Not Covered		

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care 	<ul style="list-style-type: none"> Long-term care Private-duty nursing 	<ul style="list-style-type: none"> Routine foot care Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Bariatric surgery Chiropractic care <p>Calendar Year Maximum: thirty-five (35) visits</p>	<ul style="list-style-type: none"> Hearing aids (except when over-the-counter) Infertility treatment <p>Limited to one (1) hearing aid per ear, every two (2) years Lifetime Maximum: \$12,500, including prescriptions</p>	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Routine eye care <p>Calendar Year Maximum: one (1) exam</p>

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

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 Administrator at 1-812-468-7895. 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
1-844-209-0080

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 1-844-209-0080.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-209-0080.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-209-0080.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-209-0080.

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 <u>plan's overall deductible</u>	\$3,200
■ <u>Specialist cost sharing</u>	20%
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other 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:

<i>Cost Sharing</i>	
Deductibles	\$3,200
Copayments	\$0
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$5,000

Managing Joe's type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$3,200
■ <u>Specialist cost sharing</u>	20%
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other 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:

<i>Cost Sharing</i>	
Deductibles	\$2,100
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$2,300

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$3,200
■ <u>Specialist cost sharing</u>	20%
■ <u>Hospital (facility) cost sharing</u>	20%
■ <u>Other 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:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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.