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 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	$2,000	
	Per family:	$2,000	$4,000	
Are there services covered before you meet your deductible?	Yes. 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	$10,000	
	Per family:	$6,000	$20,000	
	For prescription drug expenses, you will pay a maximum out-of-pocket of **$2,000 per participant** and **$4,000 per family**. These amounts apply towards the above medical out-of-pocket limit.			
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, and non-medically necessary services.			Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes, for medical:** Anthem. See www.anthem.com or call 1-800-331-1476 for a list of network providers. **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.	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.

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	$30 co-pay/visit, deductible waived	50% co-insurance, after deductible	Retail clinics and home visits are also covered.
	Specialist visit			
	Preventive care/screening/ immunization	No Charge	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)	20% co-insurance, after deductible	50% co-insurance, after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20% co-insurance, after deductible	50% 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	$15 co-pay per prescription; deductible waived	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 prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.maxor.com. If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription. **Prior Authorization is required** for some drugs.
	Preferred brand drugs	$45 co-pay per prescription; deductible waived	Not Covered	
	Non-preferred brand drugs	$75 co-pay per prescription; deductible waived	Not Covered	
	Specialty drugs	25% co-insurance per prescription, up to $200; deductible waived	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance, after deductible	50% 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	50% 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)	
If you need immediate medical attention	Emergency room care	**True Emergency:** 20% co-insurance, after deductible		——————————none——————————
		Non-True Emergency: $250 co-pay, then 20% co-insurance after deductible		The co-payment will be waived if the patient is admitted within twenty-four (24) hours.
	Emergency medical transportation	20% co-insurance, after deductible		**Pre-certification is required** for non-emergent air ambulance**.** Chartered air flights are not covered.
	Urgent care	20% co-insurance, after deductible	50% co-insurance, after deductible	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance, after deductible	50% co-insurance, after deductible	**Pre-certification is required.**
	Physician/surgeon fees	20% co-insurance, after deductible	50% co-insurance, after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance, after deductible	50% co-insurance, after deductible	**Pre-certification is required** for partial hospitalization and intensive outpatient programs in excess of eighteen (18) visits per calendar year. For services rendered in an office visit, see the office visit benefit.
	Inpatient services	20% co-insurance, after deductible	50% co-insurance, after deductible	**Pre-certification is required.**

* 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 are pregnant	Office visits	$30 co-pay/visit, deductible waived	50% co-insurance, after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% co-insurance, after deductible	50% co-insurance, after deductible	
	Childbirth/delivery facility services	20% co-insurance, after deductible	50% co-insurance, after deductible	
If you need help recovering or have other special needs	Home health care	20% co-insurance, after deductible	50% co-insurance, after deductible	**Pre-certification is required.**
	Rehabilitation services	$30 co-pay/visit, deductible waived	50% co-insurance, after deductible	**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.
	Habilitation services	20% co-insurance, after deductible	50% co-insurance, after deductible	For services rendered in an office visit, see the office visit benefit. 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.

* 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	Skilled nursing care	20% co-insurance, after deductible	50% co-insurance, after deductible	**Calendar Year Limit**: One hundred twenty (120) days **Pre-certification is required.**
	Durable medical equipment	20% co-insurance, after deductible	50% co-insurance, after deductible	**Pre-certification is required** for durable medical equipment in excess of $2,000 (purchase price only).
	Hospice services	20% co-insurance, after deductible	50% 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Long-term care
- 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.)

- Bariatric surgery
- Chiropractic care [Limited to thirty-five (35) visits per year]
- Hearing aids [Limited to one (1) hearing aid per ear, every two (2) years]
- Infertility treatment (Limited to $12,500 per lifetime, including prescriptions)
- Non-emergency care when traveling outside the U.S.
- Routine eye care [Limited to one (1) exam per year]

* 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, kwiijigo 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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* 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	$1,000
Specialist copayment	$30
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	$1,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,000**

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	$30
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$90
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$990**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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