**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 1-877-635-2909. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.MyAmeriBen.com or call 1-877-635-2909 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:** | $750 | N/A | |
| | **Per family:** | $2,250 | N/A | |
| **Are there services covered before you meet your deductible?** | Yes. Services paid with a co-payment (except emergency room care) and services paid at no charge. | | | This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance 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:** | $8,700 | N/A | |
| | **Per family:** | $17,400 | N/A | |
| **What is not included in the out-of-pocket limit?** | Premiums, balance billing charges (unless balance billing is prohibited), healthcare this plan doesn't cover, and penalties for failure to obtain pre-certification for 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.<br>**Medical:** See www.MyAmeriBen.com or call 1-877-635-2909 for a list of participating providers.<br>**Prescription Drugs:** See www.Navitus.com for prescription drug coverage. | | | 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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-payment/visit, deductible waived | Not Covered | BlueCare Anywhere consultations are paid at no charge. |
| | Specialist visit | $50 co-payment/visit, deductible waived | Not Covered | |
| | ACA required preventive care/screening/ immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive or required by the ACA. Ask your provider if the services needed are preventive. Then check what your plan will pay for.<br>On-site screenings are covered at no charge. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% co-insurance | Not Covered | **Pre-certification is required for imaging over $1,000.**<br>Independent labs are paid at no charge. |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | Not Covered | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at **www.navitus.com** | Generic drugs | **30-day supply:**<br>$10/prescription<br>**Up to 90-day supply:**<br>$20/prescription | | Covers a 30-day and up to a 90-day supply at retail pharmacy; up to a 90-day supply at mail order pharmacy. Specialty drugs are only available in a 30-day supply at a retail pharmacy.<br>Preventive medication and contraceptives are covered at no charge as required by law.<br>Brand-name drug penalty: if generic is available but you choose the brand name, you pay the actual cost difference plus the brand name co-payment. Quantity limits, prior authorizations, and step therapy may be required. |
| | Preferred brand drugs | **30-day supply:**<br>$30/prescription<br>**Up to 90-day supply:**<br>$60/prescription | | |
| | Non-preferred brand drugs | **30-day supply:**<br>75% of the cost of the drug<br>**Up to 90-day supply:**<br>75% of the cost of the drug | | |

* 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) | |
| | Specialty drugs | **30-day supply:** 20% co-insurance up to $150 | | Purchases at a non-participating pharmacy require you to pay in full then submit a claim form for reimbursement. Deductible does not apply to prescription drug expenses. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance | Not Covered | **Pre-certification is required for surgical procedures over $1,000.** |
| | Physician/surgeon fees | 20% co-insurance | Not Covered | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | $500 co-payment/visit, then 20% co-insurance, deductible does apply | $500 co-payment/visit, then 20% co-insurance, deductible does apply | Rates listed are for emergency services. Services for a non-emergency are not covered. Co-payment is waived if admitted. |
| | Emergency medical transportation | 20% co-insurance | 20% co-insurance | **Pre-certification is required for fixed wing air ambulance.** |
| | Urgent care | $50 co-payment | Not Covered | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% co-insurance | Not Covered | **Pre-certification is required for inpatient stays.**<br>Room & board is limited to the semi-private room rate, or if the hospital has private rooms only, 100% of the lowest private room rate. ICU as billed. |
| | Physician/surgeon fees | 20% co-insurance | Not Covered | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Primary care physician: $30 co-payment/office visit, deductible waived<br>Specialist: $50 co-payment/office visit, deductible waived | Not Covered | ——————none—————— |
| | Inpatient services | 20% co-insurance | Not Covered | **Pre-certification is required for inpatient stays.** |

* 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 | 20% co-insurance | Not Covered | If maternity charges are billed separately rather than globally, applicable office visit co-payments will apply.<br>Cost sharing does not apply for preventive services rendered by a network provider. |
| | Childbirth/delivery professional services | 20% co-insurance | Not Covered | |
| | Childbirth/delivery facility services | 20% co-insurance | Not Covered | **Pre-certification is required for an inpatient stay that is in excess of forty-eight (48) hours (vaginal delivery) or ninety-six (96) hours (caesarean delivery).** |
| **If you need help recovering or have other special needs** | Home health care | 20% co-insurance | Not Covered | **Pre-certification is required for visits and injectable medication over $1,000.**<br>**Benefit Year Maximum:** Sixty (60) visits per plan participant. |
| | Rehabilitation services | 20% co-insurance | Not Covered | **Benefit Year Maximum:** Cardiac rehab, physical, occupational, speech, and vision therapy are limited to a combined forty (40) visits per plan participant, combined with the habilitation maximum. |
| | Habilitation services | Primary care physician: $30 co-payment/office visit, deductible waived<br>Specialist: $50 co-payment/office visit, deductible waived | Not Covered | **Benefit Year Maximum:** Forty (40) visits per plan participant, combined with the rehabilitation maximum. |
| | Skilled nursing care | 20% co-insurance | Not Covered | **Pre-certification is required for inpatient stays.**<br>**Benefit Year Maximum:** Ninety (90) days per plan participant, including inpatient rehab facility. |
| | Durable medical equipment | 20% co-insurance | Not Covered | **Pre-certification is required for durable medical equipment over $1,000.** |

* 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) | |
| | Hospice services | 20% co-insurance | Not Covered | **Pre-certification is required for hospice care.**<br>**Lifetime Benefit Maximum:** One hundred-eighty (180) days per plan participant. Bereavement counseling must be done within two (2) months of the immediate family member's death. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | 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
- Cosmetic surgery
- Dental care (Adult/Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care in an emergency room
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- 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 (40 visits/plan year)
- Habilitation services (40 visits/plan 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: the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise, ID 83707, 1-877-635-2909. 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, you may 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
1-877-635-2909

**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 1-877-635-2909.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-635-2909.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-635-2909.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-635-2909.

*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, co-payments and co-insurance) 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 | $750 |
| Specialist co-payment | $50 |
| 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 | $750 |
| Co-payments | $20 |
| Co-insurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$3,170** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist co-payment | $50 |
| 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 | $750 |
| Co-payments | $700 |
| Co-insurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,510** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist co-payment | $50 |
| 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 | $750 |
| Co-payments | $500 |
| Co-insurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,500** |

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

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| 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 policy, the overall family deductible must be met before the plan begins to pay. |
| | **Per participant:** | $1,500 | $1,500 | |
| | **Per family:** | $3,000 | $3,000 | |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care from a participating provider. | | | This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance 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, the overall family out-of-pocket limit must be met. |
| | **Per participant:** | $3,000 | Unlimited | |
| | **Per family:** | $6,000 | Unlimited | |
| **What is not included in the out-of-pocket limit?** | Premiums, balance billing charges (unless balance billing is prohibited), healthcare this plan doesn't cover, and penalties for failure to obtain pre-certification for 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.<br>**Medical:** See www.MyAmeriBen.com or call 1-877-635-2909 for a list of participating providers.<br>**Prescription Drugs:** See www.Navitus.com for prescription drug coverage. | | | 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 **co-payment** and **co-insurance** 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 | 20% co-insurance | 50% co-insurance | BlueCare Anywhere consultations are paid at no charge. |
| | Specialist visit | 20% co-insurance | 50% co-insurance | |
| | ACA required preventive care/screening/ immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive or required by the ACA. Ask your provider if the services needed are preventive. Then check what your plan will pay for.<br>On-site screenings are covered at no charge. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% co-insurance | 50% co-insurance | **Pre-certification is required for imaging over $1,000.** |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | 50% co-insurance | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at **www.navitus.com** | Generic drugs | 20% co-insurance | | Covers a 30-day and up to a 90-day supply at retail pharmacy; up to a 90-day supply at mail order pharmacy. Specialty drugs are only available in a 30-day supply at a retail pharmacy.<br>Preventive medication and contraceptives are covered at no charge as required by law. This includes preventive medications on the IRS Safe Harbor list.<br>Brand-name drug penalty: if generic is available but you choose the brand name, you pay the actual cost difference plus the brand name co-payment. Quantity limits, prior authorizations, and step therapy may be |
| | Preferred brand drugs | 20% co-insurance | | |
| | Non-preferred brand drugs | 75% co-insurance | | |

* 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) | |
| | Specialty drugs | 20% co-insurance | | required.<br>Purchases at a non-participating pharmacy require you to pay in full then submit a claim form for reimbursement. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance | 50% co-insurance | **Pre-certification is required for surgical procedures over $1,000.** |
| | Physician/surgeon fees | 20% co-insurance | 50% co-insurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | 20% co-insurance | 20% co-insurance | Rates listed are for emergency services. Services for a non-emergency are not covered. |
| | Emergency medical transportation | 20% co-insurance | 20% co-insurance | **Pre-certification is required for fixed wing air ambulance.** |
| | Urgent care | 20% co-insurance | 50% co-insurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% co-insurance | 50% co-insurance | **Pre-certification is required for inpatient stays.**<br>Room & board is limited to the semi-private room rate, or if the hospital has private rooms only, 100% of the lowest private room rate.<br>ICU as billed. |
| | Physician/surgeon fees | 20% co-insurance | 50% co-insurance | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% co-insurance | 50% co-insurance | ——————none—————— |
| | Inpatient services | 20% co-insurance | 50% co-insurance | **Pre-certification is required for inpatient stays.** |
| **If you are pregnant** | Office visits | 20% co-insurance | 50% co-insurance | Cost sharing does not apply for preventive services rendered by a network provider. |
| | Childbirth/delivery professional services | 20% co-insurance | 50% co-insurance | ——————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) | |
| | Childbirth/delivery facility services | 20% co-insurance | 50% co-insurance | **Pre-certification is required for an inpatient stay that is in excess of forty-eight (48) hours (vaginal delivery) or (96) hours (caesarean delivery).** |
| **If you need help recovering or have other special needs** | Home health care | 20% co-insurance | 50% co-insurance | **Pre-certification is required for visits and injectable medication over $1,000.**<br>**Benefit Year Maximum:** Sixty (60) visits per plan participant. |
| | Rehabilitation services | 20% co-insurance | 50% co-insurance | **Benefit Year Maximum:** Cardiac rehab, physical, occupational, speech, and vision therapy are limited to a combined forty (40) visits per plan participant, combined with the habilitation maximum. |
| | Habilitation services | 20% co-insurance | 50% co-insurance | **Benefit Year Maximum:** Forty (40) visits per plan participant, combined with the rehabilitation maximum. |
| | Skilled nursing care | 20% co-insurance | 50% co-insurance | **Pre-certification is required for inpatient stays.**<br>**Benefit Year Maximum:** Ninety (90) days per plan participant, including inpatient rehab facility. |
| | Durable medical equipment | 20% co-insurance | 50% co-insurance | **Pre-certification is required for durable medical equipment over $1,000.** |
| | Hospice services | 20% co-insurance | 50% co-insurance | **Pre-certification is required for hospice care.**<br>**Lifetime Benefit Maximum:** One hundred- |

* 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) | |
| | | | | eighty (180) days per plan participant. Bereavement counseling must be done within two (2) months of the immediate family member's death. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | 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
- Cosmetic surgery
- Dental care (Adult/Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care in an emergency room
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- 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 (40 visits/plan year)
- Habilitation services (40 visits/plan year)

**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: the Plan's COBRA Administrator at AmeriBen, P.O. Box 7186, Boise, ID 83707, 1-877-635-2909. 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, you may 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
1-877-635-2909

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

## 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 1-877-635-2909.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-635-2909.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-635-2909.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-635-2909.

***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, co-payments and co-insurance) 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** | **$1,500** |
| **Specialist cost sharing** | **20%** |
| **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 | $1,500 |
| Co-payments | $0 |
| Co-insurance | $1,500 |
| *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** | **$1,500** |
| **Specialist cost sharing** | **20%** |
| **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 | $1,500 |
| Co-payments | $0 |
| Co-insurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,700** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,500** |
| **Specialist cost sharing** | **20%** |
| **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 | $1,500 |
| Co-payments | $0 |
| Co-insurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,800** |

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

# Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

## Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

## Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

## Balance Billing

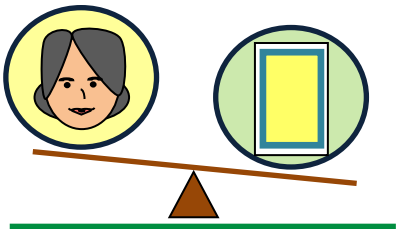
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

## Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

## Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)




(See page 6 for a detailed example.)

## Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

## Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

## Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

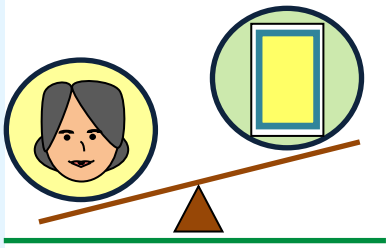
## Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

## Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

## Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

## Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

## Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

## Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

## Excluded Services

Health care services that your plan doesn't pay for or cover.

## Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

## Grievance

A complaint that you communicate to your health insurer or plan.

## Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

## Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

## Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

## In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

## In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

## Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

## Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

## Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

## Minimum Essential Coverage
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.

## Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

## Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

## Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

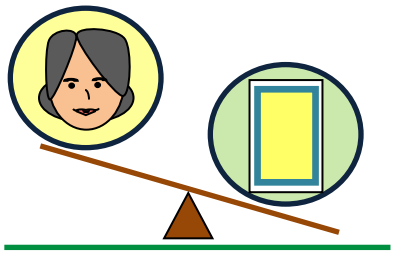
## Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

## Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

## Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

## Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

## Out-of-pocket Limit




(See page 6 for a detailed example.)

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

## Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

## Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

## Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

## Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

## Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

## Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

## Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

## Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

## Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

## Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

## Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

## Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

## Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

## UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

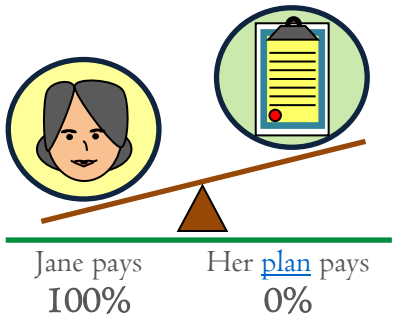
## Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

# How You and Your Insurer Share Costs - Example

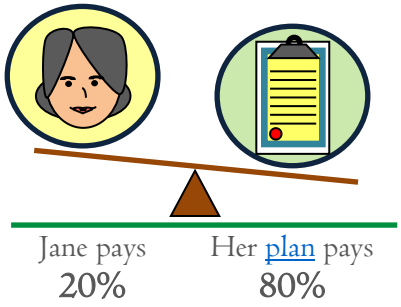
**Jane's Plan Deductible:** $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

***January 1st***
*Beginning of Coverage Period*

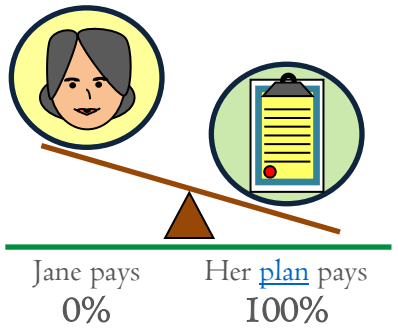
***December 31st***
*End of Coverage Period*




more costs




more costs




**Jane hasn't reached her $1,500 deductible yet**

Her plan doesn't pay any of the costs.

**Office visit costs:** $125
**Jane pays:** $125
**Her plan pays:** $0

**Jane reaches her $1,500 deductible, coinsurance begins**

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

**Office visit costs:** $125
**Jane pays:** 20% of $125 = $25
**Her plan pays:** 80% of $125 = $100

**Jane reaches her $5,000 out-of-pocket limit**

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

**Office visit costs:** $125
**Jane pays:** $0
**Her plan pays:** $125