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 1-855-961-5374. 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 1-855-961-5374 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		**Network**	**Non-Network**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Per participant:	$3,100	$8,400	
	Per family:	$6,200	$16,800	
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.			This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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:	$5,000	$15,000	
	Per family:	$10,000	$30,000	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, and non-medically necessary services.			Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes, for medical:** BCBS of Texas. See www.bcbsil.com for a list of network providers. **Yes, for prescription drugs:** CVS. For a list of retail and mail pharmacies, log on to www.caremark.com or call 1-833-992-2786.			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	20% co-insurance	40% co-insurance	——————————none——————————
	Specialist visit	20% co-insurance	40% co-insurance	——————————none——————————
	Preventive care/screening/ immunization	No charge	40% co-insurance	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	40% co-insurance	——————————none——————————
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	——————————none——————————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	20% co-insurance	Not covered	**Retail Prescriptions:** Up to thirty (30) day supply. **Mail Order Prescriptions:** Up to 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.caremark.com If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement.
	Preferred brand drugs	20% co-insurance	Not covered	
	Non-preferred brand drugs	20% co-insurance	Not covered	
	Specialty drugs	20% co-insurance	Not covered	Limited to thirty (30) day supply. Specialty drug prescriptions must be filled through CVS Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $250 per occurrence. This pre-certification requirement does not apply to in-office
	Physician/surgeon fees	20% co-insurance	40% 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)	
				surgeries, pain management injections, or colonoscopies.
If you need immediate medical attention	Emergency room care	**True Emergency:** 10% co-insurance after network deductible **Non-True Emergency:** 20% co-insurance		——————————none——————————
	Emergency medical transportation	20% co-insurance after network deductible		——————————none——————————
	Urgent care	20% co-insurance	40% co-insurance	This includes retail clinic visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $250 per occurrence.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	40% co-insurance	——————————none——————————
	Inpatient services	20% co-insurance	40% co-insurance	**Pre-certification is required** for inpatient stays. Failure to obtain pre-certification may reduce benefits by $250 per occurrence. **Pre-certification is required** for partial hospitalization and intensive outpatient program in excess of eighteen (18) visits per calendar year. Failure to obtain pre-certification may reduce benefits by $250 per occurrence.
If you are pregnant	Office visits	20% co-insurance	40% co-insurance	Cost sharing does not apply for preventive services. Depending on the type of services, co-insurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Dependent daughter pregnancies are not covered.
	Childbirth/delivery professional services	20% co-insurance	40% co-insurance	
	Childbirth/delivery facility services	20% co-insurance	40% co-insurance	
If you need help recovering or have other special needs	Home health care	20% co-insurance	40% co-insurance	**Calendar Year Maximum:** Sixty (60) days per plan participant.
	Rehabilitation services	20% co-insurance	40% co-insurance	**Calendar Year Maximum:** Sixty (60) visits for

* 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)	
				physical therapy, occupational therapy, and speech therapy combined per plan participant. **Pre-certification is required** in excess of eighteen (18) visits for physical therapy, occupational therapy, and speech therapy combined. Failure to obtain pre-certification may reduce benefits by $250 per occurrence.
	Habilitation services	20% co-insurance	40% co-insurance	——————————none——————————
	Skilled nursing care	20% co-insurance	40% co-insurance	**Calendar Year Maximum:** Ninety (90) days per plan participant, combined with rehabilitation facilities. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $250 per occurrence.
	Durable medical equipment	20% co-insurance	40% co-insurance	**Pre-certification is required** for DME in excess of $1,000 purchase price. Failure to obtain pre-certification may reduce benefits by $250 per occurrence.
	Hospice services	20% co-insurance	40% co-insurance	**Lifetime Maximum:** $10,000 per plan participant. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $250 per occurrence.
If your child needs dental or eye care	Children's eye exam	No charge	40% co-insurance	Covered for dependents ages nineteen (19) and under.
	Children's glasses	Not covered	Not covered	——————————none——————————
	Children's dental check-up	Not covered	Not covered	——————————none——————————

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

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 (except when provided in lieu of anesthetic)
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids – limited to one (1) pair every two (2) years

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 1-866-451-3399. 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
1-866-504-6814

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 1-855-961-5374.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-961-5374.

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

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-961-5374.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-961-5374.

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	$3,100
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	$3,100
Copayments	$0
Coinsurance	$1,900
What isn't covered	
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 plan's overall deductible	$3,100
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	$2,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,200**

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

The plan's overall deductible	$3,100
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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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