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 1-877-379-4844. 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 1-877-379-4844 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:	$500		
	Per family:	$1,000		
Are there services covered before you meet your deductible?	Yes. Preventive care, prescription drugs, office visits, urgent care, and hospice 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?	Yes, for prescription drugs. $200 per plan participant, $500 per family. This deductible does not apply to generic drugs.			You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these 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:	$1,000	Unlimited	
	Per family:	$3,000	Unlimited	
		Prescription Drugs		
	Per participant:	$2,500		
	Per family:	$3,500		
What is not included in the out-of-pocket limit?	Co-payments for certain services, premiums, balance-billed charges, health care this Plan doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and			Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	non-medically necessary services.	
Will you pay less if you use a network provider?	**Yes, for medical:** Anthem. See www.anthem.com/ca/sisc or call 1-877-379-4844 for a list of network providers. **Yes, for prescription drugs:** Navitus. For a list of retail and mail pharmacies, log on to www.navitus.com or call 1-866-333-2757.	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	****First Three Visits:** No Charge **After Three Visits:** $20 co-payment/visit	Billed charges exceeding non-network fee schedule, after deductible.	The office visit co-payment will apply to the office visit only. All other services rendered will pay at the applicable benefit level. ******Limited to three (3) no charge visits all office visits combined.
	Specialist visit	$20 co-payment/visit	Billed charges exceeding non-network fee schedule, after deductible.	
	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)	10% co-insurance, after deductible	Not Covered	——————————none——————————
	Imaging (CT/PET scans, MRIs)	10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, after deductible.	**Non-Network Benefit Maximum:** $800 per test. Plan participants are responsible for any amounts in excess of the maximum. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits.

* 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.navitus.com	Generic drugs	**Retail** **Costco**: No charge **All Other**: $10 co- payment/rx **Mail Order** No charge	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses a network provider.	**Retail:** Limited to thirty (30) day supply. **Mail Order:** Limited to ninety (90) day supply. **Specialty:** Limited to thirty (30) day supply. Only available when obtained through Navitus Specialty Rx. Certain narcotics and cough medications require the regular retail co-payment at Costco and three (3) times the regular co-payment when obtained through mail order. If a brand drug is dispensed when a generic equivalent is available, then the plan participant will be responsible for the generic co-payment plus the cost difference between the generic and brand. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.navitus.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. Navitus SpecialtyRx helps plan participants who are taking medications for certain chronic illnesses or complex diseases by providing services that offer convenience and support. This program is part of your pharmacy benefit and is mandatory.
	Preferred brand drugs	**Retail** **Costco**: $35 co- payment/rx **All Other**: $35 co- payment/rx **Mail Order** $90 co- payment/rx		
	Non-preferred brand drugs	**Retail** **Costco**: $35 co- payment/rx **All Other**: $35 co- payment/rx **Mail Order** $90 co- payment/rx		
	Specialty drugs	$35 co- payment/rx	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, after deductible.	**In-Network Hospital Arthroscopy Benefit Maximum:** $4,500/procedure. **In-Network Hospital Cataract Surgery**
	Physician/surgeon fees	10% co-insurance,	Billed charges exceeding	

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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)	
		after deductible	non-network fee schedule, after deductible.	**Benefit Maximum:** $2,000/procedure. **In-Network Hospital Colonoscopy Benefit Maximum:** $1,500/procedure. **In-Network Hospital Upper GI Endoscopy with Biopsy Benefit Maximum:** $1,250/procedure. **In-Network Hospital Upper GI Endoscopy without Biopsy Benefit Maximum:** $1,000/procedure. **Non-Network Benefit Maximum:** $350 per admission for ambulatory surgery centers. Plan participants are responsible for any amounts in excess of the maximum. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits.
If you need immediate medical attention	Emergency room care	$100 co-payment/visit then 10% co-insurance, after deductible		Co-payment waived if plan participant is admitted to inpatient stay.
	Emergency medical transportation	$100 co-payment/trip then 10% co-insurance, after deductible		**Benefit Maximum:** $50,000/trip for non-emergent air ambulance services. Interfacility transports are covered under the Plan as deemed medically necessary to the nearest accredited general hospital with adequate facilities for treatment or after a plan participant has been stabilized at a non-network facility and transport is needed to get to a network facility. Chartered flights are not covered. **Pre-certification is required for non-emergent air ambulance.** Failure to obtain pre-certification may reduce benefits.
	Urgent care	$20 co-payment/visit	Billed charges exceeding	The urgent care co-payment will apply to the

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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)	
			non-network fee schedule, after deductible.	visit only. All other services rendered will pay at the applicable benefit level.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, after deductible.	**Non-Network Benefit Maximum:** $600 per day. Plan participants are responsible for any amounts in excess of the maximum. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits.
	Physician/surgeon fees	10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, after deductible.	——————————none——————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	****First Three Office Visits:** No Charge **After Three Visits:** $20 co-payment/visit **All Other:** 10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, after deductible.	**Limited to three (3) no charge visits all office visits combined. **Pre-certification is required for certain services within this category.** Failure to obtain pre-certification may reduce benefits.
	Inpatient services	10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, after deductible.	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits.
If you are pregnant	Office visits	****First Three Visits:** No Charge **After Three Visits:** $20 co-payment/visit	Billed charges exceeding non-network fee schedule, after deductible.	**Limited to three (3) no charge visits all office visits combined. Cost sharing does not apply for preventive services. Depending on the type of services, a co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). **Non-Network Benefit Maximum:** $600 per day. Plan participants are responsible for any
	Childbirth/delivery professional services	10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, after deductible.	
	Childbirth/delivery facility services	10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, 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)	
				amounts in excess of the maximum.
If you need help recovering or have other special needs	Home health care	10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, after deductible.	**Calendar Year Visit Maximum:** one hundred (100) visits network and non-network providers combined. **Non-Network Benefit Maximum:** $150 per day. Plan participants are responsible for any amounts in excess of the maximum. One (1) visit by a home health aide equals four (4) hours or less. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits.
	Rehabilitation services Habilitation services	10% co-insurance, after deductible	Not Covered	Following the first five (5) visits, all physical therapy and occupational therapy services are subject to medical necessity review. If the service is within the first five (5) visits per plan participant, per provider, the service will be automatically authorized. Non-network providers are not covered.
	Skilled nursing care	10% co-insurance, after deductible	Billed charges exceeding non-network fee schedule, after deductible.	**Calendar Year Visit Maximum:** one hundred fifty (150) days network and non-network providers combined. **Non-Network Benefit Maximum:** $600 per day. Plan participants are responsible for any amounts in excess of the maximum. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits.
	Durable medical equipment	10% co-insurance, after deductible	Not Covered	**Calendar Year Maximum:** therapeutic shoes and inserts for plan participants with diabetes limited to two (2) pairs. **Pre-certification is required in excess of $1,000 (purchase/rental price).** Failure to obtain pre-certification may reduce benefits.

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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	No Charge	Billed charges exceeding non-network fee schedule, after deductible.	Respite care limited to five (5) consecutive days per admission.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	——————————none——————————
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	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.)

- Cosmetic Surgery (except when due to trauma or disease)
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private Duty Nursing (except when as rendered as part of covered home health care)
- 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.)

- Acupuncture [limited to twelve (12) visits per calendar year]
- Bariatric Surgery
- Chiropractic Care (subject to a medical necessity review)
- Hearing Aids [limited to $700 per plan participant every twenty-four (24) month period)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may contact the Plan's COBRA Administrator at P.O. Box 966, Bakersfield, CA 93302, 1-661-636-4410. 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. 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
1-866-504-6814

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

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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 1-877-379-4844.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-379-4844.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-877-379-4844.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-379-4844.

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	$500
Specialist co-payment	$20
Hospital (facility) cost sharing	10%
Other cost sharing	10%

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	$500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,000**

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

The plan's overall deductible	$500
Specialist co-payment	$20
Hospital (facility) cost sharing	10%
Other cost sharing	10%

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	$300
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$300
The total Joe would pay is	**$700**

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

The plan's overall deductible	$500
Specialist co-payment	$20
Hospital (facility) cost sharing	10%
Other cost sharing	10%

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	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

*This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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