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, coupehealth.com or call 1-833-597-3980. 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.dol.gov/ebsa/healthreform or call 1-833-597-3980 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		**Network**	**Non-Network**	See the Common Medical Events chart below for your costs for services this plan covers.
	Per participant:	$3,500		
	Per family:	$7,000		
Are there services covered before you meet your deductible?	**Yes.** Preventive services.			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:	$7,000		
	Per family:	$14,000		
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan doesn't cover, out-of-network benefits, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, 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:** Anthem. See www.coupehealth.com or call 1-833-597-3980 for a list of network providers. **Yes, for prescription drugs:** CarelonRX. For a list of retail and mail pharmacies, call1-833-271-2375.			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.

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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)	
		Tier 1	Tier 2	Tier 3		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay	$25 co-pay	$40 co-pay	$50 co-pay	Co-payment applies to all services billed by the provider on the same claim for the same date of service. Telehealth benefits available.
	Specialist visit	$35 co-pay	$50 co-pay	$80 co-pay	$95 co-pay	
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	$50 co-pay	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)	**Routine Diagnostic Labs** $10 co-pay **Diagnostic Labs** $50 co-pay **Diagnostic Radiology** $50 co-pay	**Routine Diagnostic Labs** $15 copay **Diagnostic Labs** $65 co-pay **Diagnostic Radiology** $65 co-pay	**Routine Diagnostic Labs** $30 co-pay **Diagnostic Labs** $105 co-pay **Diagnostic Radiology** $105 co-pay	**Routine Diagnostic Labs** $35 co-pay **Diagnostic Labs** $125 co-pay **Diagnostic Radiology** $125 co-pay	**Pre-certification is required for some services in this category.**
	Imaging (CT/PET scans, MRIs)	$165 co-pay	$215 co-pay	$365 co-pay	$435 co-pay	**Pre-certification is required for some services in this category.**

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.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)	
		Retail	Mail Order		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-833-271-2375.	Generic drugs	30% co-insurance	30% co-insurance	Not Covered	**Retail:** thirty (30) to ninety (90) day supply **Mail Order:** ninety (90) day supply Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, call 1-833-271-2375. 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	30% co-insurance	30% co-insurance	Not Covered	
	Non-preferred brand drugs	30% co-insurance	30% co-insurance	Not Covered	
	Specialty drugs	30% co-insurance	30% co-insurance	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.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)	
		Tier 1	Tier 2	Tier 3		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$535 co-pay	$715 co-pay	$1,205 co-pay	$1,445 co-pay	**Pre-certification is required for some services in this category.**
	Physician/ surgeon fees					
If you need immediate medical attention	Emergency room care	$305 co-pay per visit				Co-payment is waived if admitted.
	Emergency medical transportation	$305 co-pay per transport				**Pre-certification is required for non-emergency transport.**
	Urgent care	$35 co-pay per visit				——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,640 co-pay	2,180 co-pay	$3,690 co-pay	$4,425 co-pay	**Pre-certification is required.**
	Physician/ surgeon fees					
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 co-pay	$25 co-pay	$40 co-pay	$50 co-pay	**Pre-certification is required for some services in this category.**
	Inpatient services	$1,640 co-pay	2,180 co-pay	$3,690 co-pay	$4,425 co-pay	**Pre-certification is required.**
If you are pregnant	Office visits	$20 co-pay	$25 co-pay	$40 co-pay	$50 co-pay	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). **Pre-certification is required for stays longer than forty-eight (48) hours (vaginal delivery) or ninety-six (96) hours (cesarean delivery).**
	Childbirth/delivery professional services	$1,640 co-pay	$2,180 co-pay	$3,690 co-pay	$4,425 co-pay	
	Childbirth/delivery facility services					
If you need help recovering or have other special needs	Home health care	$35 co-pay	$50 co-pay	$80 co-pay	$95 co-pay	**Calendar Year Maximum:** one hundred (100) visits **Pre-certification is required for some services in this category.**

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.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)	
		Tier 1	Tier 2	Tier 3		
If you need help recovering or have other special needs	Rehabilitation services	$35 co-pay	$50 co-pay	$80 co-pay	$95 co-pay	**Calendar Year Maximum:** twenty-five (25) visits per therapy type
	Habilitation services	$35 co-pay	$50 co-pay	$80 co-pay	$95 co-pay	
	Skilled nursing care	$1,445 co-pay	$1,920 co-pay	$3,250 co-pay	$3,900 co-pay	**Calendar Year Maximum:** one hundred twenty (120) days **Pre-certification is required for some services in this category.**
	Durable medical equipment	$75 co-pay	$100 co-pay	$170 co-pay	$205 co-pay	**Pre-certification is required for some services in this category.**
	Hospice services	$180 co-pay	$240 co-pay	$405 co-pay	$485 co-pay	**Outpatient Lifetime Maximum:** one hundred eighty (80) days **Inpatient Lifetime Maximum:** thirty (30) days **Coverage limited to those who have been certified as having twelve (12) months or less to live.**
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Not Covered	Separate vision plan is offered.
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	Separate vision plan is offered.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	Separate dental plan is offered.

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
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care (except when medically necessary)
- Weight loss programs

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

- Acupuncture
  Calendar Year Maximum: twenty (20) visits
- Bariatric surgery
- Chiropractic care
  Calendar Year Maximum: twenty-five (25) visits
- Hearing aids
  External Hearing Aid Limit: two (2) units up to $3,000 per ear every thirty-six (36) months
  Over-the-Counter Hearing Aid Lifetime Maximum: one (1) hearing aid per ear
  Written recommendation by a provider is required.
- Private-duty nursing (subject to the Home Health Care maximum)

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.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 1-833-597-3980. 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 claims administrator to assist the plan administrator with claims adjudication. The claims administrator name, address, and telephone number are:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-833-597-3980

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 1-833-597-3980.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-597-3980.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-597-3980.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-597-3980.

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 coupehealth.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	$3,500
Specialist co-payment	$35
Hospital (facility) co-payment	$1,640
Other co-payment	$50

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	$3,500
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$5,420**

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

The plan's overall deductible	$3,500
Specialist co-payment	$35
Hospital (facility) co-payment	$1,640
Other co-payment	$50

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	$2,300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,300**

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

The plan's overall deductible	$3,500
Specialist co-payment	$35
Hospital (facility) co-payment	$1,640
Other co-payment	$50

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**

Coverage Examples assume usage of Tier 1 providers.

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

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma
sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID
卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của
tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각
장애인이신가요? 다른 형식으로
된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga
format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи
на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы
со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու
ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi
di vista? È possibile richiedere anche altri formati di
questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache
zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert?
Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei
ID Card. Hoscht Druwwel fer sehne? Du kannscht des
do Schreiwes in en differnter Weg griege so as du's
besser sehne kannscht.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the

Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator,
P.O. Box 7186 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for
Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf