
 **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](http://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](http://www.dol.gov/ebsa/healthreform) or call 1-833-597-3980 to request a copy.

Important Questions	Answers			Why This Matters:
<b>What is the overall deductible?</b>		<b>Network</b>	<b>Non-Network</b>	See the Common Medical Events chart below for your costs for services this plan covers.
	<b>Per participant:</b>		\$0	
	<b>Per family:</b>		\$0	
<b>Are there services covered before you meet your deductible?</b>	<b>No.</b>			You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
<b>Are there other deductibles for specific services?</b>	<b>No.</b>			You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>		<b>Network</b>	<b>Non-Network</b>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
	<b>Per participant:</b>		\$6,500	
	<b>Per family:</b>		\$13,000	
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, <u>out-of-network</u> 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 <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	<b>Yes, for medical:</b> Anthem. See <a href="http://www.coupehealth.com">www.coupehealth.com</a> or call 1-833-597-3980 for a list of network providers.  <b>Yes, for prescription drugs:</b> CarelonRX. For a list of retail and mail pharmacies, log on to <a href="http://www.website.com">www.website.com</a> or call 1-833-271-2375.			This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	<b>No.</b>			You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	\$35 co-pay	\$50 co-pay	\$80 co-pay	\$100 co-pay	<u>Co-payment</u> applies to all services billed by the provider on the same claim for the same date of service. Telehealth benefits available.
	<u>Specialist</u> visit	\$65 co-pay	\$85 co-pay	\$145 co-pay	\$175 co-pay	
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	No Charge	\$100 co-pay	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	<b>Routine Diagnostic Labs</b> \$25 co-pay	<b>Routine Diagnostic Labs</b> \$35 copay	<b>Routine Diagnostic Labs</b> \$55 co-pay	<b>Routine Diagnostic Labs</b> \$65 co-pay	<b>Pre-certification is required for some services in this category.</b>
		<b>Diagnostic Labs</b> \$95 co-pay	<b>Diagnostic Labs</b> \$125 co-pay	<b>Diagnostic Labs</b> \$210 co-pay	<b>Diagnostic Labs</b> \$250 co-pay	
		<b>Diagnostic Radiology</b> \$95 co-pay	<b>Diagnostic Radiology</b> \$125 co-pay	<b>Diagnostic Radiology</b> \$210 co-pay	<b>Diagnostic Radiology</b> \$250 co-pay	
	Imaging (CT/PET scans, MRIs)	\$315 co-pay	\$415 co-pay	\$700 co-pay	\$840 co-pay	<b>Pre-certification is required for some services in this category.</b>

\* For more information about limitations and exceptions, see the plan or policy document at [coupehealth.com](https://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		
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at 1-833-271-2375	Generic drugs	\$20 co-payment	\$40 co-payment	Not Covered	<b>Retail:</b> thirty (30) to ninety (90) day supply  <b>Mail Order:</b> ninety (90) day supply  Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u> , call 1-833-271-2375.  If you obtain <u>prescription drugs</u> 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	\$60 co-payment	\$120 co-payment	Not Covered	
	Non-preferred brand drugs	50% co-insurance <b>Minimum \$80</b> <b>Maximum \$100</b>	50% co-insurance <b>Minimum \$160</b> <b>Maximum \$200</b>	Not Covered	
	<u>Specialty drugs</u>	50% co-insurance <b>Minimum \$80</b> <b>Maximum \$120</b>	50% co-insurance <b>Minimum \$200</b> <b>Maximum \$240</b>	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at [coupehealth.com](http://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)	\$1,065 co-pay	\$1,415 co-pay	\$2,400 co-pay	\$2,880 co-pay	Pre-certification is required for some services in this category.
	Physician/surgeon fees					
If you need immediate medical attention	Emergency room care	\$600 co-pay per visit				Co-payment is waived if admitted.
	Emergency medical transportation	\$600 co-pay per transport				Pre-certification is required for non-emergency transport.
	Urgent care	\$65 co-pay per visit				_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	\$3,255 co-pay	\$4,330 co-pay	\$6,500 co-pay	\$8,800 co-pay	Pre-certification is required.
	Physician/surgeon fees					
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 co-pay	\$50 co-pay	\$80 co-pay	\$100 co-pay	Pre-certification is required for some services in this category.
	Inpatient services	\$3,255 co-pay	\$4,330 co-pay	\$6,500 co-pay	\$8,800 co-pay	Pre-certification is required.
If you are pregnant	Office visits	\$35 co-pay	\$50 co-pay	\$80 co-pay	\$100 co-pay	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	\$3,255 co-pay	\$4,330 co-pay	\$6,500 co-pay	\$8,800 co-pay	Depending on the type of services, a co-payment, co-insurance, or deductible may apply.
	Childbirth/delivery facility services					Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special needs						Pre-certification is required for stays longer than forty-eight (48) hours (vaginal delivery) or ninety-six (96) hours (cesarean delivery).
	Home health care	\$65 co-pay	\$85 co-pay	\$145 co-pay	\$175 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	<u>Rehabilitation services</u>	\$65 co-pay	\$85 co-pay	\$145 co-pay	\$175 co-pay	<b>Calendar Year Maximum:</b> twenty-five (25) visits per therapy type
	<u>Habilitation services</u>	\$65 co-pay	\$85 co-pay	\$145 co-pay	\$175 co-pay	
	<u>Skilled nursing care</u>	\$2,875 co-pay	\$3,825 co-pay	\$6,500 co-pay	\$7,770 co-pay	<b>Calendar Year Maximum:</b> one hundred twenty (120) days <b>Pre-certification is required for some services in this category.</b>
	<u>Durable medical equipment</u>	\$150 co-pay	\$200 co-pay	\$340 co-pay	\$410 co-pay	<b>Pre-certification is required for some services in this category.</b>
	<u>Hospice services</u>	\$345 co-pay	\$460 co-pay	\$775 co-pay	\$935 co-pay	<b>Outpatient Lifetime Maximum:</b> one hundred eighty (80) days <b>Inpatient Lifetime Maximum:</b> thirty (30) days <b>Coverage limited to those who have been certified as having twelve (12) months or less to live.</b>
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.)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (adult)</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine eye care (adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care (except when medically necessary)</li> <li>• Weight loss programs</li> </ul> |
|--|--|---|

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

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture<br/><b>Calendar Year Maximum:</b> twenty (20) visits</li> <li>• Bariatric surgery</li> <li>• Chiropractic care<br/><b>Calendar Year Maximum:</b> twenty-five (25) visits</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids<br/><b>External Hearing Aid Limit:</b> two (2) units up to \$3,000 per ear every thirty-six (36) months<br/><b>Over-the-Counter Hearing Aid Lifetime Maximum:</b> one (1) hearing aid per ear<br/><b>Written recommendation by a provider is required.</b></li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing (subject to the Home Health Care maximum)</li> </ul> |
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\* For more information about limitations and exceptions, see the plan or policy document at [coupehealth.com](http://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](http://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](http://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](http://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, kwijigo holne' 1-833-597-3980.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

\* For more information about limitations and exceptions, see the plan or policy document at [coupehealth.com](http://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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> co-payment	\$65
■ Hospital (facility) co-payment	\$3,255
■ Other <u>co-payment</u>	\$95

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$4,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$4,020</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> co-payment	\$65
■ Hospital (facility) co-payment	\$3,255
■ Other <u>co-payment</u>	\$95

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,100
<b>The total Joe would pay is</b>	<b>\$1,100</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> co-payment	\$65
■ Hospital (facility) co-payment	\$3,255
■ Other <u>co-payment</u>	\$95

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

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 fòm 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 ունեցող 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 uffrueff 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>