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 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:	$0	$0	
	Per family:	$0	$0	
Are there services covered before you meet your deductible?	Not Applicable			
Are there other deductibles for specific services?	Yes. $50 for Prescription Drugs. There are no other specific deductibles.			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:	$6,900	$20,000	
	Per family:	$13,800	$40,000	
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, 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:** CVS Caremark. See www.caremark.com for a list of network retail and mail order pharmacies.			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 Network Provider (You will pay the least)			Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Green Tier	Yellow Tier	Red Tier		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	$50 copay	$80 copay	$95 copay	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 copay	$70 copay	$100 copay	$200 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service. Telehealth benefits available.
	Preventive care/screening/ immunization	No Charge	No Charge	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)	**Routine Diagnostic Labs** $35 copay **Diagnostic Labs** $115 copay **Diagnostic Radiology** $115 copay	**Routine Diagnostic Labs** $70 copay **Diagnostic Labs** $200 copay **Diagnostic Radiology** $200 copay	**Routine Diagnostic Labs** $100 copay **Diagnostic Labs** $300 copay **Diagnostic Radiology** $300 copay	**Routine Diagnostic Labs** $200 copay **Diagnostic Labs** $350 copay **Diagnostic Radiology** $350 copay	**Pre-certification is required for some services in this category.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
	Imaging (CT/PET scans, MRIs)	$400 copay	$600 copay	$900 copay	$1,100 copay	

* 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 Network Provider (You will pay the least)			Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Green Tier	Yellow Tier	Red Tier		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Tier 1 - Generic drugs	$20 copay (retail) $30 copay (mail order)			50% coinsurance ($75 minimum) (retail and mail order)	Prescription drug deductible applies to retail and mail order prescriptions in- and out-of-network. 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.
	Tier 2 - Preferred brand drugs	$55 copay (retail) $70 copay (mail order)			50% coinsurance ($75 minimum) (retail and mail order)	
	Tier 3 - Non-preferred brand drugs	$75 copay (retail) $90 copay (mail order)			50% coinsurance ($75 minimum) (retail and mail order)	
	Tier 4 - Specialty drugs	20% coinsurance up to $500 maximum (retail) Not covered (mail order)			50% coinsurance ($75 minimum) (retail) Not covered (mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,300 copay	$1,800 copay	$3,000 copay	$3,500 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service. **Pre-certification is required for some services in this category.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
	Physician/surgeon fees					
If you need immediate medical attention	Emergency room care	$750 copay	$750 copay	$750 copay	$750 copay	Co-payment applies per ER visit. Waived if admitted.
	Emergency medical transportation	$750 copay	$750 copay	$750 copay	$750 copay	Co-payment applies per transport. **Pre-certification is required for non-emergency transport.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
	Urgent care	$100 copay	$100 copay	$100 copay	$300 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	$4,000 copay	$5,500 copay	$6,900 copay	$10,000 copay	Co-payment applies per admission. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.

* 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 Network Provider (You will pay the least)			Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Green Tier	Yellow Tier	Red Tier		
	Physician/surgeon fees					Co-payment applies to all services billed by the provider on the same claim for the same date of service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay	$50 copay	$80 copay	$95 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service. Telehealth benefits available. **Pre-certification is required for some services in this category.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
	Inpatient services	$4,000 copay	$5,500 copay	$6,900 copay	$10,000 copay	Co-payment applies per admission. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
If you are pregnant	Office visits	$25 copay	$50 copay	$80 copay	$95 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service.
	Childbirth/delivery professional services	$4,000 copay	$5,500 copay	$6,900 copay	$10,000 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service. Cost sharing does not apply for preventive services. Depending on the type of services, a co-payment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Co-payment applies per admission. **Pre-certification is required for stays longer than 48 hours (vaginal delivery) or 96 hours (cesarean delivery).** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
	Childbirth/delivery facility services					

* 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 Network Provider (You will pay the least)			Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Green Tier	Yellow Tier	Red Tier		
If you need help recovering or have other special needs	Home health care	$100 copay	$130 copay	$215 copay	$300 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service. **Calendar year maximum:** 135 visits **Pre-certification is required for some services in this category.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
	Rehabilitation services	$35 copay	$70 copay	$100 copay	$200 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service.
	Habilitation services	$35 copay	$70 copay	$100 copay	$200 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service.
	Skilled nursing care	**Inpatient facility** $4,000 copay	**Inpatient facility** $5,500 copay	**Inpatient facility** $6,900 copay	**Inpatient facility** $10,000 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service. **Pre-certification is required for some services in this category.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
	Durable medical equipment	$185 copay	$250 copay	$415 copay	$500 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service. **Pre-certification is required for some services in this category.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
	Hospice services	$450 copay	$600 copay	$950 copay	$1,200 copay	Co-payment applies to all services billed by the provider on the same claim for the same date of service.
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.

* For more information about limitations and exceptions, see the plan or policy document at coupehealth.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
- Cosmetic surgery
- Dental care (Adult)
- Elective abortion
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care (unless diagnosed with diabetes)
- 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 (12 visits/year)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (135 visits/lifetime including home health care)

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

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	$50
Specialist co-payment	$35
Hospital (facility) co-payment	$4,000
Other co-payment	$115

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	$30
Copayments	$6,870
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6,900**

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

The plan's overall deductible	$50
Specialist co-payment	$35
Hospital (facility) co-payment	$4,000
Other co-payment	$115

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	$50
Copayments	$1000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,050**

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

The plan's overall deductible	$50
Specialist co-payment	$35
Hospital (facility) co-payment	$4,000
Other co-payment	$115

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	$0
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

Coverage Examples assume usage of Tier 1 providers. Deductible amount is specific to prescription drugs.

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