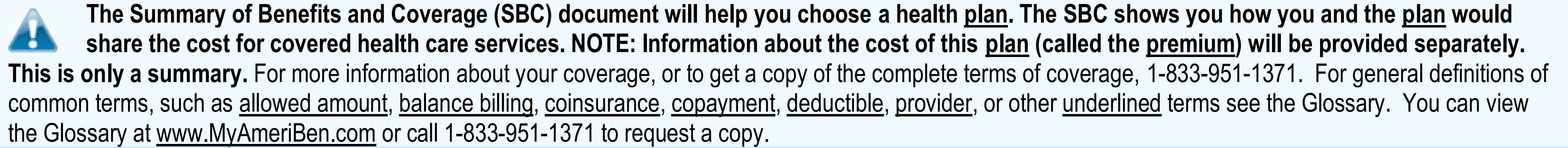
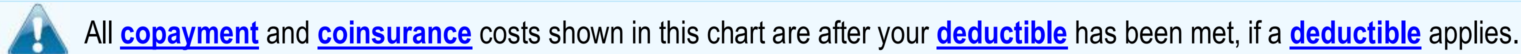


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 1-833-951-1371. 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 1-833-951-1371 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:	$2,000	$4,000	
	Per participant within family:	$2,800	$5,600	
	Per family:	$4,000	$8,000	
Are there services covered before you meet your deductible?	Yes. Preventive services for network providers			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:	$3,000	$6,000	
	Per family:	$6,000	$12,000	
What is not included in the out-of-pocket limit?	Premiums, cost containment penalties, items not covered under the plan, charges in excess of plan's maximum benefits, amounts over the maximum allowable charges, and balanced billed charges.			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 Blue Cross. See www.anthem.com/ca or call 1-800-688-3828 for a list of network providers.			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

	Yes, for prescription drugs: Costco Pharmacy. For a list of retail and mail pharmacies, log on to www.costcohealthsolutions.com or call 1-877-908-6024.	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.



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	10% co-insurance after deductible	40% co-insurance after deductible	For other services received during an office visit, additional cost share may apply.
	Specialist visit	10% co-insurance after deductible	40% co-insurance 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)	**Free-standing Facility:** 10% co-insurance after deductible **Outpatient Hospital:** $25 co-payment/visit after deductible + 10% co-insurance after deductible	40% co-insurance after deductible	**Outpatient Hospital Services:** $350 per day maximum allowed amount for non-network providers. Plan participants are responsible for 40% of this $350 per day, plus all charges in excess of $350.
	Imaging (CT/PET scans, MRIs)	**Radiology Center:** 10% co-insurance after deductible **Outpatient Hospital:** $100 co-payment/visit after deductible + 10% co-insurance after deductible	40% co-insurance 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.costcohealthsolutions.com	Generic drugs	**Costco Retail:** $5 co-payment after deductible **Retail:** $10 co-payment after deductible **Mail Order (Costco Only):** $10 co-payment after deductible	Not covered	**Retail:** Limited to thirty (30) day supply. **Mail Order:** Limited to ninety (90) day supply. Co-payments are per prescription. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.costcohealthsolutions.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. **Pre-certification is required** for some specialty drugs. Failure to obtain pre-certification will result in a denial of benefits unless retroactive review of services proves medical necessity.
	Preferred brand drugs	**Costco Retail:** $15 co-payment after deductible **Retail:** $25 co-payment after deductible **Mail Order (Costco Only):** $30 co-payment after deductible	Not covered	
	Non-preferred brand drugs	**Costco Retail:** $30 co-payment after deductible **Retail:** $40 co-payment after deductible **Mail Order (Costco Only):** $60 co-payment after deductible	Not covered	
	Specialty drugs	20% co-insurance after deductible	Not Covered	Costco Specialty Services is the exclusive provider for specialty medications as part of

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)	
				the prescription drug plan and is mandatory. Any specialty drug co-payment assistance program that is paid by a drug manufacturer or other third party will not count towards the deductible or out-of-pocket maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after deductible	40% co-insurance after deductible	$350 per day maximum allowed amount for non-network providers. Plan participants are responsible for 40% of this $350 per day, plus all charges in excess of $350. **Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits unless retroactive review of services proves medical necessity.
	Physician/surgeon fees	10% co-insurance after deductible	40% co-insurance after deductible	———none———
If you need immediate medical attention	Emergency room care	$100 co-payment/visit after deductible + 10% co-insurance after deductible	$100 co-payment/visit after deductible + 10% co-insurance after deductible	Co-payment is waived if admitted.
	Emergency medical transportation	10% co-insurance after deductible	10% co-insurance after deductible	———none———
	Urgent care	10% co-insurance after deductible	40% co-insurance after deductible	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 co-payment/visit after deductible + 10% co-insurance after deductible	40% co-insurance after deductible	$600 per day maximum allowed amount for non-network providers. Plan participants are responsible for 40% of this $600 per day, plus all charges in excess of $600. **Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits unless retroactive review of services proves medical necessity.
	Physician/surgeon fees	10% co-insurance after deductible	40% co-insurance after deductible	———none———

* 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 mental health, behavioral health, or substance abuse services	Outpatient services	10% co-insurance after deductible	40% co-insurance after deductible	**Outpatient Hospital Services:** $350 per day maximum allowed amount for non-network providers. Plan participants are responsible for 40% of this $350 per day, plus all charges in excess of $350. **Pre-certification is required** for intensive outpatient and partial hospitalization. Failure to obtain pre-certification will result in a denial of benefits unless retroactive review of services proves medical necessity.
	Inpatient services	$100 co-payment/visit after deductible + 10% co-insurance after deductible	40% co-insurance after deductible	$600 per day maximum allowed amount for non-network providers. Plan participants are responsible for 40% of this $600 per day, plus all charges in excess of $600. **Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits unless retroactive review of services proves medical necessity.
If you are pregnant	Office visits	10% co-insurance after deductible	40% co-insurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of service, co-insurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% co-insurance after deductible	40% co-insurance after deductible	
	Childbirth/delivery facility services	$100 co-payment/visit after deductible + 10% co-insurance after deductible	40% co-insurance after deductible	$600 per day maximum allowed amount for non-network providers. Plan participants are responsible for 40% of this $600 per day, plus all charges in excess of $600.
If you need help recovering or have other special needs	Home health care	10% co-insurance after deductible	40% co-insurance after deductible	**Calendar Year Maximum:** One hundred (100) days for network and non-network services combined. **Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits unless retroactive review of services

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)	
				proves medical necessity.
	Rehabilitation services	10% co-insurance after deductible	40% co-insurance after deductible	Rehabilitation services are limited to physical, occupational, speech and respiratory therapies. **Calendar Year Maximum:** Twenty-five (25) visits per calendar year per therapy type. **Outpatient Hospital Services:** $350 per day maximum allowed amount for non-network providers. Plan participants are responsible for 40% of this $350 per day, plus all charges in excess of $350.
	Habilitation services	10% co-insurance after deductible	40% co-insurance after deductible	**Outpatient Hospital Services:** $350 per day maximum allowed amount for non-network providers. Plan participants are responsible for 40% of this $350 per day, plus all charges in excess of $350.
	Skilled nursing care	10% co-insurance after deductible	40% co-insurance after deductible	**Calendar Year Maximum:** One hundred (100) days for network and non-network services combined. **Inpatient Hospital Services:** $600 per day maximum allowed amount for non-network providers. Plan participants are responsible for 40% of this $600 per day, plus all charges in excess of $600. **Pre-certification is required.** Failure to obtain pre-certification will result in a denial of benefits unless retroactive review of services proves medical necessity.
	Durable medical equipment	10% co-insurance after deductible	40% co-insurance after deductible	**Pre-certification is required** for some services. Failure to obtain pre-certification will result in a denial of benefits unless retroactive review of services proves medical necessity.
	Hospice services	0% after deductible	0% after deductible	**Inpatient Respite Care:** Limited to five (5)

* 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)	
				consecutive days maximum per confinement on a limited basis.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Plan participant must enroll in separate vision plan for vision benefits.
	Children's glasses	Not Covered	Not Covered	Plan participant must enroll in separate vision plan for vision benefits.
	Children's dental check-up	Not Covered	Not Covered	Plan participant must enroll in separate dental plan for dental benefits.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- 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.)

- Abortion
- Acupuncture – limited to twenty (20) visits per calendar year, network and non-network services combined.
- Chiropractic care – limited to twenty (20) visits per calendar year, network and non-network services combined.
- Infertility treatment – covered through Kindbody

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 1-800-424-3052. 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
1-833-951-1371

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-833-951-1371.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-951-1371.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-951-1371.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-951-1371.

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

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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** **$2,000**
- **Specialist cost sharing** **10%**
- **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	$2,000
Copayments	$100
Coinsurance	$900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,000**

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

- **The plan's overall deductible** **$2,000**
- **Specialist cost sharing** **10%**
- **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	$1,100
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

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

- **The plan's overall deductible** **$2,000**
- **Specialist cost sharing** **10%**
- **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	$2,000
Copayments	$10
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,090**

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