


**⚠ 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, [www.commercialroofingbenefits.com](http://www.commercialroofingbenefits.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.MyAmeriBen.com](http://www.MyAmeriBen.com) or call 1-866-504-6813 to request a copy.

Important Questions	Answers			Why This Matters:
<b>What is the overall deductible?</b>		<b>Network</b>	<b>Non-Network</b>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
	<b>Per participant:</b>	\$1,000	\$2,000	
	<b>Per family:</b>	\$3,000	\$6,000	
<b>Are there services covered before you meet your deductible?</b>	<b>Yes.</b> Allergy testing, serum, and injections, birthing centers, chiropractic treatment/spinal manipulation, CVS Minute Clinics & Walgreen Take Care Clinics, hearing aids, <u>home health care</u> , <u>hospice care</u> , the injectable contraceptive benefit, medical records requests, office visits, outpatient lab and x-ray, preventive care skilled nursing facility, rehabilitation facility, removal of wisdom teeth, and <u>urgent care</u> facility.			This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>co-payment</u> or <u>co-insurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<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 out-of-pocket limit for this plan?</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>	\$4,000	\$10,000	
	<b>Per family:</b>	\$12,000	\$25,000	
<b>What is not included in the out-of-pocket limit?</b>	Premiums, <u>balance-billed</u> charges, penalty amounts, health care this <u>plan</u> doesn't cover, and prescription drug charges. Prescription drug changes apply toward their own out-of-pocket limit.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

\* For more information about limitations and exceptions, see the plan or policy document at [www.MyAmeriBen.com](http://www.MyAmeriBen.com).

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	<p><b>Yes</b>, medical.  <b>N. and S. Carolina:</b> Med Cost.            Call 1-800-824-7406 or go to <a href="http://www.medcost.com">www.medcost.com</a>.  <b>All Other Locations:</b> Aetna Signature Administrators. Call 1-866-504-6813 or go to <a href="http://www.aetna.com/ASAconnect">www.aetna.com/ASAconnect</a>.</p> <p><b>Yes</b>, pharmacy. Navitus Health Solutions.            Call 1-866-333-2757 or go to <a href="http://www.navitus.com">www.navitus.com</a>.</p>	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 provider's 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 provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	<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)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$10 co-payment/visit	50% co-insurance after deductible	_____none_____
	<u>Specialist</u> visit	\$15 co-payment/visit	50% co-insurance after deductible	
	<u>Preventive care/screening/immunization</u>	No Charge	50% co-insurance after deductible	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge	50% co-insurance after deductible	Laboratory, diagnostic, and x-ray services that are provided by an <u>out-of-network provider</u> through a <u>referral</u> of an <u>in-network</u> physician will be paid at the <u>in-network</u> rate.
	Imaging (CT/PET scans, MRIs)	40% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-Certification is required.</b> Failure to pre-certify will subject you to a 50% penalty up to a maximum of \$500 for any resulting <u>claims</u> .

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.navitus.com">www.navitus.com</a>	Generic drugs	<b>Pharmacy Option (30 day supply):</b> No Charge  <b>Mail Order Option (90 day supply):</b> No Charge	Network Price	Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u> , log into your account at <a href="http://www.navitus.com">www.navitus.com</a> .  If you purchase your <u>prescription drugs</u> from a non-participating pharmacy, you will have to pay the full price of the prescription and then submit a <u>claim</u> for reimbursement. Reimbursement will be according to the <u>network</u> price, so your total out-of-pocket cost may likely be greater than the co-payment you would have paid if you had used a <u>network</u> pharmacy.  Generic prescription medications mandated under the Affordable Care Act (including contraceptives) received by a <u>network</u> pharmacy are covered at 100% and the <u>deductible/co-payment</u> (if applicable) is waived.
	Preferred brand drugs	<b>Pharmacy Option (30 day supply):</b> \$10 co-payment  <b>Mail Order Option (90 day supply):</b> \$20 co-payment	Network Price	
	Non-preferred brand drugs	<b>Pharmacy Option (30 day supply):</b> \$20 co-payment  <b>Mail Order Option (90 day supply):</b> \$40 co-payment	Network Price	
	<u>Specialty drugs</u>	<b>Pharmacy Option (30 day supply):</b> \$100 co-payment	Network Price	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% co-insurance after deductible	50% co-insurance after deductible	<b>Pre-certification is required</b> except when rendered in the emergency room. Failure to pre-certify will subject you to a 50% penalty up to a maximum of \$500 for any resulting <u>claims</u> .  —————none—————
	Physician/surgeon fees	40% co-insurance after deductible	50% co-insurance after deductible	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$350 co-payment/visit, then 40% co-insurance after deductible	\$350 co-payment/visit, then 40% co-insurance after deductible	<u>Co-payment</u> waived if admitted.  Diagnostic services performed in the emergency room are paid at the outpatient diagnostic service, lab and x-ray benefit level.

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 immediate medical attention	<u>Emergency medical transportation</u>	40% co-insurance after deductible	40% co-insurance after <u>network</u> deductible	_____none_____
	<u>Urgent care</u>	\$10 co-payment/visit	50% co-insurance after deductible	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	40% co-insurance after deductible	50% co-insurance after deductible	Limited to semi-private room rate except as <u>medically necessary</u> . <b>Pre-certification is required.</b> Failure to pre-certify will subject you to a 50% penalty up to a maximum of \$500 for any resulting <u>claims</u> .
	Physician/surgeon fees	40% co-insurance after deductible	50% co-insurance after deductible	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% co-insurance after deductible	50% co-insurance after deductible	Services include medication management, partial <u>hospitalization</u> , and intensive outpatient services. <b>Pre-certification is required</b> for inpatient treatment. Failure to pre-certify will subject you to a 50% penalty up to a maximum of \$500 for any resulting <u>claims</u> .
	Inpatient services	40% co-insurance after deductible	50% co-insurance after deductible	
If you are pregnant	Office visits	\$10 co-payment/visit	50% co-insurance after deductible	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	40% co-insurance after deductible	50% co-insurance after deductible	Depending on the type of services, a <u>co-insurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	<b>Birthing Center</b> No Charge  <b>All Other Inpatient Facilities</b> 40% co-insurance after deductible	<b>Birthing Center</b> No Charge  <b>All Other Inpatient Facilities</b> 50% co-insurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <b>Pre-certification is required</b> for a hospital stay that exceeds forty-eight (48) hours for a vaginal birth and ninety-six (96) hours for a cesarean section birth. Failure to pre-certify will subject you to a 50% penalty up to a maximum of \$500 for any resulting <u>claims</u> .

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	No Charge	Limited to an annual maximum of forty (40) visits per plan participant.
	<u>Rehabilitation services</u>	<b>Inpatient Facilities</b> No Charge  <b>Other</b> 40% co-insurance after deductible	<b>Inpatient Facilities</b> No Charge  <b>Other</b> 50% co-insurance after deductible	<b>Pre-certification is required for cardiac rehabilitation and inpatient rehabilitation facilities.</b> Failure to pre-certify will subject you to a 50% penalty up to a maximum of \$500 for any resulting <u>claims</u> .
	<u>Habilitation services</u>	40% co-insurance after deductible	50% co-insurance after deductible	_____none_____
	<u>Skilled nursing care</u>	No Charge	No Charge	<b>Pre-certification is required.</b> Failure to pre-certify will subject you to a 50% penalty up to a maximum of \$500 for any resulting <u>claims</u> .
	<u>Durable medical equipment</u>	40% co-insurance after deductible	50% co-insurance after deductible	_____none_____
	<u>Hospice services</u>	No Charge	No Charge	Hospice care plan must certify life expectancy of six (6) months or less.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	No Charge	No charge up to \$300 annually; includes exams, lenses, frames, contacts, and hardware.
	Children's glasses	No Charge	No Charge	
	Children's dental check-up	No Charge	No Charge	One (1) every six (6) months, up to age nineteen (19).

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b>		
<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> </ul>

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

- Acupuncture – limited to \$500/benefit year
- Bariatric surgery (as defined in the plan document for Morbid Obesity) – limited to one (1) surgical procedure/lifetime. **Pre-certification is required.**
- Chiropractic care – limited to \$500/benefit year
- Cosmetic surgery (as defined as an eligible expense in the plan document)
- Hearing aids – limited to \$2,000/benefit year
- Long-term care (acute care only). **Pre-certification is required.**
- Private duty nursing (as defined as an eligible expense in the plan document)
- Routine eye care (Adult)
- Weight loss programs (as defined in the plan document for Morbid Obesity)

**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 at Progressive Services, Inc. dba Commercial Roofing Benefits, 23 N. 35th Avenue, Phoenix, AZ, 85009 1-602-278-4900. 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 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  
1-866-504-6813

**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 1-866-504-6813.  
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-504-6813.  
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-504-6813.  
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-504-6813.

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

## 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 overall deductible</u>	\$1000
■ <u>Specialist co-payment</u>	\$15
■ <u>Hospital (facility) cost sharing</u>	40%
■ <u>Other cost sharing</u>	40%

#### 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:

<i>Cost Sharing</i>	
Deductibles	\$0
Co-payments	\$10
Co-insurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$20</b>

This coverage example assumes the use of a birthing center and that the baby is enrolled in the Plan.

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's overall deductible</u>	\$1000
■ <u>Specialist co-payment</u>	\$15
■ <u>Hospital (facility) cost sharing</u>	40%
■ <u>Other cost sharing</u>	40%

#### 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>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Co-payments	\$200
Co-insurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$600</b>

### Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$1000
■ <u>Specialist co-payment</u>	\$15
■ <u>Hospital (facility) cost sharing</u>	40%
■ <u>Other cost sharing</u>	40%

#### 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>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Co-payments	\$400
Co-insurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

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