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. 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 **1-866-504-6813** 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:	$500	$1,000	
	Per family:	$1,500	$3,000	
Are there services covered before you meet your deductible?	**Yes.** Allergy testing, serum, and injections, birthing centers, chiropractic treatment/spinal manipulation, CVS Minute Clinics & Walgreen Take Care Clinics, hearing aids, home health care, hospice care, 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 urgent care facility.			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	$10,000	
	Per family:	$9,000	$25,000	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalty amounts, health care this plan 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 out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes**, medical. **N. and S. Carolina:** Med Cost. Call 1-800-824-7406 or go to www.medcost.com. **All Other Locations:** Aetna Signature Administrators. Call 1-866-504-6813 or go to www.aetna.com/ASAconnect. **Yes,** pharmacy. Navitus Health Solutions. Call 1-866-333-2757 or go to www.navitus.com.	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		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	$5 co-payment/visit	50% co-insurance after deductible	——————none——————
	Specialist visit	$10 co-payment/visit	50% co-insurance after deductible	
	Preventive care/screening/ immunization	No Charge	50% co-insurance after deductible	Immunizations include the HPV series of injections for plan participants from age nine (9) to twenty-six (26) years of age.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% co-insurance after deductible	Laboratory, diagnostic, and x-ray services that are provided by an out-of-network provider through a referral of an in-network physician will be paid at the in-network rate.
	Imaging (CT/PET scans, MRIs)	30% co-insurance after deductible	50% co-insurance after deductible	**Pre-Certification is required.** Failure to pre-certify will subject you to a 50% penalty up to a maximum of $500 for any resulting claims.

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.navitus.com	Generic drugs	**Pharmacy Option (30 day supply):** No Charge **Mail Order Option (90 day supply):** No Charge	Network Price	Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.navitus.com. If you purchase your prescription drugs from a non-participating pharmacy, your will have to pay the full price of the prescription and then submit a claim for reimbursement. Reimbursement will be according to the network 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 network pharmacy. Generic prescription medications mandated under the Affordable Care Act (including contraceptives) received by a network pharmacy are covered at 100% and the deductible/co-payment (if applicable) is waived.
	Preferred brand drugs	**Pharmacy Option (30 day supply):** $10 co-payment **Mail Order Option (90 day supply):** $20 co-payment	Network Price	
	Non-preferred brand drugs	**Pharmacy Option (30 day supply):** $20 co-payment **Mail Order Option (90 day supply):** $40 co-payment	Network Price	
	Specialty drugs	**Pharmacy Option (30 day supply):** $100 co-payment	Network Price	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance after deductible	50% co-insurance after deductible	**Pre-certification is required** 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 claims.
	Physician/surgeon fees	30% co-insurance after deductible	50% co-insurance after deductible	——————————none——————————
If you need immediate medical attention	Emergency room care	$350 co-payment/visit, then 30% co-insurance after deductible	$350 co-payment/visit, then 30% co-insurance after deductible	Co-payment 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	Emergency medical transportation	30% co-insurance after deductible	30% co-insurance after network deductible	——————————none——————————
	Urgent care	$5 co-payment/visit	50% co-insurance after deductible	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance after deductible	50% co-insurance after deductible	Limited to semi-private room rate except as medically necessary. **Pre-certification is required.** Failure to pre-certify will subject you to a 50% penalty up to a maximum of $500 for any resulting claims.
	Physician/surgeon fees	30% co-insurance after deductible	50% co-insurance after deductible	——————————none——————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% co-insurance after deductible	50% co-insurance after deductible	Services include medication management, partial hospitalization, and intensive outpatient services. **Pre-Certification is required** for inpatient treatment. Failure to pre-certify will subject you to a 50% penalty up to a maximum of $500 for any resulting claims.
	Inpatient services	30% co-insurance after deductible	50% co-insurance after deductible	
If you are pregnant	Office visits	$5 co-payment/visit	50% co-insurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a 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 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 claims.
	Childbirth/delivery professional services	30% co-insurance after deductible	50% co-insurance after deductible	
	Childbirth/delivery facility services	**Birthing Center** No Charge **All Other Inpatient Facilities** 30% co-insurance after deductible	**Birthing Center** No Charge **All Other Inpatient Facilities** 50% co-insurance after deductible	

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 help recovering or have other special health needs	Home health care	No Charge	No Charge	Limited to an annual maximum of forty (40) visits per plan participant.
	Rehabilitation services	**Inpatient Facilities** No Charge **Other** 30% co-insurance after deductible	**Inpatient Facilities** No Charge **Other** 50% co-insurance after deductible	**Pre-certification is required for cardiac rehabilitation and inpatient rehabilitation facilities.** Failure to pre-certify will subject you to a 50% penalty up to a maximum of $500 for any resulting claims.
	Habilitation services	30% co-insurance after deductible	50% co-insurance after deductible	——————none——————
	Skilled nursing care	No Charge	No Charge	**Pre-certification is required.** Failure to pre-certify will subject you to a 50% penalty up to a maximum of $500 for any resulting claims.
	Durable medical equipment	30% co-insurance after deductible	50% co-insurance after deductible	——————none——————
	Hospice services	No Charge	No Charge	Hospice care plan must certify life expectancy of six (6) months or less.
If your child needs dental or eye care	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:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Dental care (Adult)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine foot care

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. **Precertification 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). **Precertification 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. You may also contact the Plan Administrator 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 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
1-866-504-6814

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, kwiijigo holne' 1-866-504-6813.

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 plan's overall deductible	**$500**
Specialist co-payment	**$10**
Hospital (facility) cost sharing	**30%**
Other cost sharing	**30%**

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	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$20**

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 plan's overall deductible	**$500**
Specialist co-payment	**$10**
Hospital (facility) cost sharing	**30%**
Other cost sharing	**30%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$600**

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

The plan's overall deductible	**$500**
Specialist co-payment	**$10**
Hospital (facility) cost sharing	**30%**
Other cost sharing	**30%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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