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, contact AmeriBen at 1-866-955-1482. 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 1-866-955-1482 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	$1,250	
	Per family:	$1,250	$2,500	
Are there services covered before you meet your deductible?	**Yes.** Acupuncture, alternative medicine, ambulance services, bone density screenings, breast feeding pump and supplies, chiropractic care, City Medical Clinic services, network colonoscopies, network diabetic insulin pumps and supplies, dietician, drug screenings, emergency physician services, emergency room services, network EPHC primary care physicians and Tier 1 specialists, Health Management programs, network hearing aids, mammograms, network medicine monitoring, nutritionist, network outpatient mental health and substance abuse/chemical dependency, network oxygen equipment and supplies, prescription drugs, routine wellness, network preventive care, and network urgent care.			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:	$2,500	$4,050	
	Per family:	$7,500	$12,150	

Important Questions	Answers	Why This Matters:
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 maximum allowed amounts, and penalties.	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. For a list of network providers, call Anthem, at 1-800-676 BLUE or visit www.anthem.com **Yes, for prescription drugs:** MaxorPlus. For a list of retail and mail pharmacies, log on to www.maxor.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	**EPHC** $25 co-payment/visit **All Other Providers** $35 co-payment/visit	50% co-insurance	——————none——————
	Specialist visit	**Tier 1** $40 co-payment/visit **All Other Providers** $60 co-payment/visit	50% co-insurance	
	Preventive care/screening/ immunization	No Charge	50% co-insurance	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)	20% co-insurance	50% co-insurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% co-insurance	50% co-insurance	

* 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
		City Employee Pharmacy (You will pay the least)	Network Provider: MaxorPlus (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.cityemployeepharmacy.com** OR **www.maxor.com**	Generic drugs	**Thirty (30) Day Supply** $6 co-payment **Ninety (90) Day Supply** $15 co-payment	**Thirty (30) Day Supply** $25 co-payment **Ninety (90) Day Supply** Not Covered	Any amounts in the form of coupons used for brand name drugs when there is a generic equivalent available, unless the brand name is medically necessary, does not apply to the out-of-pocket limit. Plan participants will progressively pay higher co-payments for maintenance prescriptions that are filled at a MaxorPlus Retail Network Pharmacy versus the City Employee Pharmacy. **Some medications may be subject to quantity limitations and/or pre-certification.** Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.cityemployeepharmacy.com OR www.maxor.com. If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription.
	Preferred brand drugs	**Thirty (30) Day Supply** $35 co-payment **Ninety (90) Day Supply** $70 co-payment	**Thirty (30) Day Supply** $55 co-payment **Ninety (90) Day Supply** Not Covered	
	Non-preferred brand drugs	**Thirty (30) Day Supply** $60 co-payment **Ninety (90) Day Supply** $120 co-payment	**Thirty (30) Day Supply** $75 co-payment **Ninety (90) Day Supply** Not Covered	
	Specialty drugs	**Preferred/Tier 4)** *20% co-insurance up to a $100 co-payment **Non-Preferred/Tier 5** *20% co-insurance up to a $150 co-payment	Not Covered	*Co-insurance is waived and the full co-payment is applied for specialty drugs bought without co-payment assistance. Specialty drugs are covered only up to a thirty (30) day supply. Maxor Specialty Pharmacy Patient Care Advocates will assist members with enrollment with manufacturer copay assistance programs if available (*Please note that not all specialty medications will have copay assistance available; those medications that do have assistance available are subject to availability and may be discontinued at any time*). Any portion known to have been paid by a secondary payer (*i.e. patient assistance, copay cards, or other insurance*) will not be considered as true member out-of-pocket and will not apply to deductible and out-of-pocket maximums.

* 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Freestanding Facility** 10% co-insurance **UCHealth Memorial Facility** 15% co-insurance **Other** 20% co-insurance	50% co-insurance	——————none——————
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$250 co-payment		**Pre-certification is required for all hospital admissions.** Failure to obtain pre-certification within forty-eight (48) hours of admission may result in your claim being denied.
	Emergency medical transportation	$100 co-payment	$100 co-payment	——————none——————
	Urgent care	$50 co-payment	50% co-insurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**UCHealth Memorial Facility** 15% co-insurance **All Other Facilities** 20% co-insurance	50% co-insurance	**Pre-certification is required.** Failure to obtain pre-certification may result in your claim being denied.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 co-payment	50% co-insurance	One (1) annual mental health wellness exam is covered at no charge.
	Inpatient services	**UCHealth Memorial Facility** 15% co-insurance **All Other Facilities** 20% co-insurance	50% co-insurance	**Pre-certification is required.** Failure to obtain pre-certification may result in your claim being denied.

* 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 are pregnant	Office visits	**EPHC PCP** $25 co-payment **Tier 1 Specialist** $40 co-payment **PCP (Other)** $35 co-payment **Specialist (Other)** $60 co-payment	50% co-insurance	Co-payment applies to the first office visit only.
	Childbirth/delivery professional services	**UCHealth Memorial Facility** 15% co-insurance **All Other Facilities** 20% co-insurance	50% co-insurance	——————————none——————————
	Childbirth/delivery facility services			
If you need help recovering or have other special needs	Home health care	20% co-insurance	50% co-insurance	**Covers up to two (2) hours in a twenty-four (24) hour period.**
	Rehabilitation services	**Outpatient** $35 co-payment **UCHealth Memorial Facility (Inpatient)** 15% co-insurance **Other (Inpatient)** 20% co-insurance	50% co-insurance	**Outpatient Rehabilitation Services Maximum:** one-hundred eighty (180) days per illness/injury **Benefit Year Maximum (Other):** sixty (60) visits, combined **Pre-certification is required for outpatient pediatric rehabilitation therapy up to age ten (10) and hospital admissions.** Failure to obtain pre-certification may result in your claim being denied.
	Habilitation services			

* 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 help recovering or have other special needs	Skilled nursing care	20% co-insurance	50% co-insurance	**Lifetime Maximum:** three-hundred sixty-five (365) days **Pre-certification is required.** Failure to obtain pre-certification may result in your claim being denied.
	Durable medical equipment	0% co-insurance	50% co-insurance	——————————none——————————
	Hospice services	$150 one-time co-payment	50% co-insurance	——————————none——————————
If your child needs dental or eye care	Children's eye exam	No Charge	50% co-insurance	**Covered only for plan participants up to age eighteen (18) who are not enrolled in The City of Colorado Springs' VSP.** **Routine only.**
	Children's glasses	Not Covered	Not Covered	——————————none——————————
	Children's dental check-up	Not Covered	Not Covered	——————————none——————————

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.)

- Abortion (except in cases of rape, incest, or when the mother's life is in danger)
- Cosmetic Surgery
- Dental Care (Adult)
- Non-Emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care (except when medically necessary)

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

- Acupuncture: **Calendar Year Maximum:** twenty (20) visits
- Bariatric Surgery
- Chiropractic Care: **Calendar Year Maximum:** twenty (20) visits
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Weight Loss Programs

* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.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: You may also contact the Plan at The City of Colorado Springs, 30 S. Nevada Avenue, P.O. Box 1575, Mail Code 322, Colorado Springs, CO 80901-1575, 719-385-5125. 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:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-866-504-6814

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: 1-866-955-1482.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa: 1-866-955-1482.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码: 1-866-955-1482.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne': 1-866-955-1482.

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 www.MyAmeriBen.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	$500
Specialist copayment	$40
Hospital (facility) cost sharing	15%
Other cost sharing	20%

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	$500
Copayments	$10
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,030**

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 copayment	$40
Hospital (facility) cost sharing	15%
Other cost sharing	20%

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	$500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) cost sharing	15%
Other cost sharing	20%

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	$500
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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