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 www.ecsd.myameriben.com or call 1-833-951-1376. 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.ecsd.myameriben.com or call 1-833-951-1376 to request a copy.

<table>
<tr><th>Important Questions</th><th>Answers</th><th>Why This Matters:</th></tr>
<tr><td rowspan="3">What is the overall deductible?</td><td>
<table>
<tr><td></td><td>Network</td><td>Non-Network</td></tr>
<tr><td>Per participant:</td><td>$600</td><td>$700</td></tr>
<tr><td>Per family:</td><td>$1,300</td><td>$2,100</td></tr>
</table>
</td><td rowspan="3">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.</td></tr>
<tr><td>Are there services covered before you meet your deductible?</td><td>Yes. Network office visits, some network preventive care, and services with a co-payment.</td><td>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.</td></tr>
<tr><td>Are there other deductibles for specific services?</td><td>Yes. Prescription drugs and dental.
<table>
<tr><td></td><td>Network</td><td>Non-Network</td></tr>
<tr><td colspan="3">Prescription Drug Deductible</td></tr>
<tr><td>Per participant:</td><td>$50</td><td>Not Applicable</td></tr>
<tr><td>Per family:</td><td>$100</td><td>Not Applicable</td></tr>
<tr><td colspan="3">Dental Deductible</td></tr>
<tr><td>Per participant:</td><td>$50</td><td>Not Applicable</td></tr>
</table>
</td><td>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.</td></tr>
<tr><td>What is the out-of-pocket limit for this plan?</td><td>
<table>
<tr><td></td><td>Network</td><td>Non-Network</td></tr>
<tr><td>Per participant:</td><td>$3,000</td><td>$6,000</td></tr>
</table>
</td><td>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.</td></tr>
<tr><td>What is not included in the out-of-pocket limit?</td><td>Co-payments, deductibles, 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.</td><td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td></tr>
</table>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes, for medical:** Anthem. See www.anthem.com or call 1-833-951-1376 for a list of network providers. **Yes, for prescription drugs:** IngenioRx. For a list of retail and mail pharmacies, log on to www.ingenio-rx.com or call 1-833-267-2133.	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	$35 co-payment, deductible waived, up to $200 per visit; then 20% co-insurance, deductible waived	40% co-insurance after deductible	Co-payment applies per provider, per day. Office visit co-payment includes diagnostic testing, labs, and x-rays performed at the office visit.
	Specialist visit	$50 co-payment, deductible waived, up to $200 per visit; then 20% co-insurance, deductible waived	40% co-insurance after deductible	
	Preventive care/screening/ immunization	**Adult:** No Charge, deductible waived **Child [Up to Age Eighteen (18)]:** $35 co-payment per visit, deductible waived	40% co-insurance after deductible	Benefit includes routine physical examinations, immunizations, and related labs and x-rays. Colonoscopies are not included in the preventive care benefit. 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 after deductible	40% co-insurance after deductible	Diagnostic testing performed in a physician's office will apply to the Office Visit benefit.

* For more information about limitations and exceptions, see the plan or policy document at www.ecsd.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)	
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	——————————none——————————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ingenio-rx.com	Generic drugs	**Retail (30-Day Supply):** $15 co-payment/ prescription **Retail (90-Day Supply):** $25 co-payment/ prescription **Mail Order:** $20 co-payment/ prescription	Not Covered	**Retail Supply Limit*:** 30-Day or 90-Day Supply. **Mail Order Supply Limit*:** Up to a 90-Day Supply. *Specialty drugs are limited to a 30-day supply. A separate deductible will apply to prescription drugs per calendar year. Refer to the "Are there other deductibles for specific services?" row. Prior authorization, dispense as written (DAW) requirements, and step therapy requirements may apply. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.ingenio-rx.com.
	Preferred brand drugs	**Retail (30-Day Supply):** $25 co-payment/ prescription **Retail (90-Day Supply):** $35 co-payment/ prescription **Mail Order:** $30 co-payment/ prescription	Not Covered	
	Non-preferred brand drugs	**Retail (30-Day Supply):** $35 co-payment/ prescription **Retail (90-Day Supply):** $50 co-payment/ prescription **Mail Order:** $45 co-payment/ prescription	Not Covered	
	Specialty drugs	25% co-insurance after prescription drug deductible, up to $500 per prescription	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.ecsd.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)	20% co-insurance after deductible	40% co-insurance after deductible	**Pre-certification is required.** Failure to pre-certify may reduce benefits by 50% per occurrence.
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need immediate medical attention	Emergency room care	**True Emergency:** $100 co-payment per visit, then 20% co-insurance, deductible waived		The co-payment will be waived if the plan participant is admitted directly to the hospital from the emergency room.
		Non-True Emergency: $100 co-payment per visit, then 20% co-insurance, deductible waived	$100 co-payment per visit, then 40% co-insurance, deductible waived	
	Emergency medical transportation	20% co-insurance after deductible		——————————none——————————
	Urgent care	20% co-insurance after deductible	40% co-insurance after deductible	——————————none——————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	**Pre-certification is required.** Failure to pre-certify may reduce benefits by 50% per occurrence.
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visits:** $35 co-payment, deductible waived, up to $200 per visit; then 20% co-insurance, deductible waived **All Other Services:** 20% co-insurance after deductible	40% co-insurance after deductible	——————————none——————————
	Inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	**Pre-certification is required.** Failure to pre-certify may reduce benefits by 50% per occurrence.

* For more information about limitations and exceptions, see the plan or policy document at www.ecsd.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	20% co-insurance after deductible	40% co-insurance after deductible	Dependent child pregnancy is not covered. Depending on the type of services, a co-payment, 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 inpatient stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery.** Failure to pre-certify may reduce benefits by 50% per occurrence.
	Childbirth/delivery professional services	20% co-insurance after deductible	40% co-insurance after deductible	
	Childbirth/delivery facility services	20% co-insurance after deductible	40% co-insurance after deductible	
If you need help recovering or have other special needs	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	**Calendar Year Maximum:** Forty (40) visits per plan participant.
	Rehabilitation services	**Physical Therapy:** $25 co-payment per visit, deductible waived **Occupational and Speech Therapy:** 20% co-insurance after deductible	40% co-insurance after deductible	**Physical Therapy Calendar Year Maximum:** Twenty (20) visits per plan participant. After twenty (20) visits, additional visits are subject to a medical necessity review.
	Habilitation services			
	Skilled nursing care	20% co-insurance after deductible	40% co-insurance after deductible	**Calendar Year Maximum:** Sixty (60) days per plan participant. This maximum does not apply to rehabilitation facilities. **Pre-certification is required.** Failure to pre-certify may reduce benefits by 50% per occurrence.
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	——————————none——————————
	Hospice services	20% 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.ecsd.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 your child needs dental or eye care	Children's eye exam	No Charge*		*There is no deductible for vision benefits. **Calendar Year Maximum:** $245 per plan participant for all eligible vision care charges combined. Includes frames, lenses, contacts, and eye exams.
	Children's glasses	No Charge*		
	Children's dental check-up	No Charge, deductible waived		**Calendar Year Maximum:** Two (2) per plan participant.

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)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Orthodontia
- Private-Duty Nursing (Outpatient)
- Routine Eye Care (Adult)
- Routine Foot Care

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

- Bariatric Surgery
- Chiropractic Care (Limited to $1,000 per Calendar Year)
- Weight Loss Programs (Limited to Physician-Supervised Clinics)

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 the Plan's COBRA Administrator at AmeriBen, P.O. Box 7565, Boise, ID 83707, 1-833-951-1376. 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 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
1-833-951-1376

* For more information about limitations and exceptions, see the plan or policy document at www.ecsd.myameriben.com.

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 1-833-951-1376.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-951-1376.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-833-951-1376.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-951-1376.

*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.ecsd.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	$600
Specialist co-payment	$50
Hospital (facility) cost sharing	20%
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	$610*
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,930**

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

The plan's overall deductible	$600
Specialist co-payment	$50
Hospital (facility) cost sharing	20%
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	$100*
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	$600
Specialist co-payment	$50
Hospital (facility) cost sharing	20%
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	$600*
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

*This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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