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. Medical Records Requests, Birthing Center, Skilled Nursing Facility, Rehabilitation Facility, Urgent Care, Acupuncture, Allergy Testing, Serum and Injections, Chiropractic Treatment/Spinal Manipulations, CVS Minute Clinics & Walgreens Take Care Clinics, Hearing Aid, Home Health Care, Hospice Care, Injectable Contraceptive Benefit (prescribed by a physician), Outpatient Lab and X-Ray, Office Visit, Removal of Wisdom Teeth, and Preventive 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:	$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.aetnaconnect.aetnasignatureadministrators.com/. 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% 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. Amounts assessed under this penalty will not go towards satisfaction of your Out-Of-Pocket Maximum.

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):** $0 co-payment **Mail Order Option (90 day supply):** $0 co-payment	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. Amounts assessed under this penalty will not go towards satisfaction of your Out-of-Pocket Maximum.
	Physician/surgeon fees	30% co-insurance after deductible	50% co-insurance after deductible	——————none——————
If you need immediate medical attention	Emergency room care	$150 co-payment/visit, then 30% co-insurance after deductible	$150 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.

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	**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. Amounts assessed under this penalty will not go towards satisfaction of your Out-of-Pocket Maximum. Limited to semi-private room rate except as medically necessary.
	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	**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. Amounts assessed under this penalty will not go towards satisfaction of your Out-of-Pocket Maximum. Services include medication management, partial hospitalization, and intensive Outpatient services.
	Inpatient services	30% co-insurance after deductible	50% co-insurance after deductible	
If you are pregnant	Office visits	100% after $5 co-pay/visit	50% 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).
	Childbirth/delivery professional services	Birthing center: 100% deductible waived All other inpatient facilities: 30% after deductible	Birthing Center: 100% deductible waived All other inpatient facilities: 50% after deductible	
	Childbirth/delivery facility services	Birthing center: 100% deductible waived All other inpatient facilities: 30% after deductible	Birthing Center: 100% deductible waived All other inpatient facilities: 50% 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	30% co-insurance after deductible	50% co-insurance after deductible	Inpatient Rehabilitation Facility: No Charge. **Pre-certification is required.** Limited to an annual maximum of sixty (60) days per plan participant combined with Skilled Nursing and Rehabilitation Facilities. Cardiac Rehabilitation requires pre-certification. Failure to pre-certify will subject you to a 50% penalty up to a maximum of $500 for any resulting claims. Amounts assessed under this penalty will not go towards satisfaction of your Out-of-Pocket Maximum.
	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. Amounts assessed under this penalty will not go towards satisfaction of your Out-of-Pocket Maximum. Limited to an annual maximum of sixty (60) days per plan participant combined with Skilled Nursing and Rehabilitation Facilities.
	Durable medical equipment	30% co-insurance after deductible	50% co-insurance after deductible	Refer to the Plan Document, Covered Charges section, Durable Medical Equipment.
	Hospice services	No Charge	No Charge	Limited to a lifetime maximum (inpatient and outpatient) of one-hundred eighty (180) days per plan participant.
If your child needs dental or eye care	Children's eye exam	No Charge up to max	No Charge up to max	No Charge up to $300 annually; includes exams, lenses, frames, contacts, and hardware.
	Children's glasses	No Charge up to max	No Charge up to max	
	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 annually
- Bariatric surgery (as defined in the Plan Document for Morbid Obesity) Precertification is required. Lifetime maximum of one surgical procedure.
- Chiropractic care – limited to $500 annually
- Cosmetic surgery (as defined as an Eligible Expense in the Plan Document)
- Hearing aids (annual maximum of $2,000 / 30% coinsurance)
- 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

Peg is Having a Baby
(9 months of in-network pre-

- **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	$700
Copayments	$400
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,200**

This coverage example

Managing Joe's type 2 Diabetes

- **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	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$700**

Mia's Simple Fracture
(in-network emergency room

- **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	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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