This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.MyAmeriBen.com or www.commercialroofingbenefits.com or by calling **1-866-504-6813**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network:** $1,000 per plan participant $3,000 per family **Non-Network:** $2,000 per plan participant; $6,000 per family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**No**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes.** **Network:** $4,000 per plan participant $12,000 per family **Non-Network:** $10,000 per plan participant $25,000 per family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	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	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

	www.aetna.com/asa. Yes, pharmacy. Navitus Health Solutions call 1-866-333-2757 or go to www.navitus.com.	
Do I need a referral to see a specialist?	**No.** You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment	50% coinsurance after deductible	——————none——————
	Specialist visit	$40 copayment	50% coinsurance after deductible	——————none——————
	Other practitioner office visit	Allergy Testing, Serum , and Injections: No Charge Acupuncture and Chiropractic Treatment $25 copayment	50% coinsurance after deductible	Acupuncture is limited to an annual maximum of $500 per plan participant. Chiropractic treatment is limited to an annual maximum of $500 per plan participant.
	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% coinsurance 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.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	40% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required. Failure to precertify 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.
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): $5 copayment Mail Order Option (90 day supply): $10 copayment	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/copayment (if applicable) is waived.
	Preferred brand drugs	Pharmacy Option (30 day supply): $45 copayment Mail Order Option (90 day supply): $90 copayment	Network Price	
	Non-preferred brand drugs	Pharmacy Option (30 day supply): $65 copayment Mail Order Option (90 day supply): $130 copayment	Network Price	
	Specialty drugs	Pharmacy Option (30 day supply): $100 copayment	Network Price	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required except when rendered in the Emergency Room. Failure to precertify 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	40% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you need immediate medical attention	Emergency room services	$150 copayment, then 40% coinsurance after deductible	$150 copayment, then 40% coinsurance after deductible	Copayment waived if admitted. Diagnostic services performed in the Emergency Room are paid at the Outpatient Diagnostic Service, Lab and X-ray benefit.
	Emergency medical transportation	40% coinsurance after deductible	40% coinsurance after Network deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Urgent care	$30 copayment	50% coinsurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required. Failure to precertify 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 fee	40% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	40% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required for Inpatient treatment. Failure to precertify 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.
	Mental/Behavioral health inpatient services	40% coinsurance after deductible	50% coinsurance after deductible	
	Substance use disorder outpatient services	40% coinsurance after deductible	50% coinsurance after deductible	
	Substance use disorder inpatient services	40% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Prenatal and postnatal care	40% coinsurance after deductible	50% coinsurance after deductible	Dependent child pregnancy is limited to mandated preventive screenings only. Please see the plan document for further details.
	Delivery and all inpatient services	40% coinsurance after deductible	50% coinsurance after deductible	Birthing Centers are paid at No Charge.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Limited to an annual maximum of 40 visits per plan participant
	Rehabilitation services	40% coinsurance after deductible	50% coinsurance after deductible	Inpatient Rehabilitation Facility: No Charge. Precertification is required. Limited to an annual maximum of 60 days per plan participant combined with Skilled Nursing and Rehabilitation Facilities. Cardiac Rehabilitation requires precertification. Failure to precertify 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	40% coinsurance after deductible	50% coinsurance after deductible	————————none————————
	Skilled nursing care	No Charge	No Charge	Precertification is required. Failure to precertify 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 60 days per plan participant combined with Skilled Nursing and Rehabilitation Facilities.
	Durable medical equipment	40% coinsurance after deductible	50% coinsurance after deductible	Refer to the Plan Document, Section IV, H. Covered Charges, Durable Medical Equipment.
	Hospice service	No Charge	No Charge	Limited to a lifetime maximum (inpatient and outpatient) of 180 days per plan participant.
If your child needs dental or eye care	Eye exam	No Charge up to max	No Charge up to max	No Charge up to $200 annually; includes exams, lenses, frames, contacts, and hardware.
	Glasses	No Charge up to max	No Charge up to max	
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

- Infertility treatment

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- 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)
- Dental check-up (child)
- Hearing aids (annual maximum of $2,000 / 40% 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
- Weight loss programs (as defined in the Plan Document for Morbid Obesity)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at Progressive Services, Inc. dba Commercial Roofing Benefits, 23 N. 35th Avenue, Phoenix, AZ, 85009 1-602-278-4900. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can 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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy **does provide** minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage **does meet** the minimum value standard for the benefits it provides.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,550
- **Patient pays** $3,960

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,900
Copays	$30
Coinsurance	$2,000
Limits or exclusions	$30
Total	**$3,960**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,830
- **Patient pays** $ 570

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$400
Coinsurance	$0
Limits or exclusions	$70
Total	**$570**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.