
 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.MyAmeriBen.com or call 1-866-438-0185. 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 1-866-438-0185 to request a copy.

Important Questions	Answers				Why This Matters:
What is the overall <u>deductible</u> ?		Open Access III Providers	Network	Non-Network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
	Per participant	\$500	\$1,000	\$2,000	
	Per family	\$1,000	\$2,000	\$4,000	
Are there services covered before you meet your <u>deductible</u> ?	Yes, Open Access III <u>preventive care</u> and <u>network preventive care</u> services and prescription drugs.				This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.				You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?		Open Access III Providers	Network	Non-Network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
	Per participant	\$2,500	\$3,000	\$5,000	
	Per family	\$5,000	\$6,000	\$7,500	
What is not included in the <u>out-of-pocket limit</u> ?	Specialty drug co-payments, pre-certification penalties, amounts in excess of the reasonable and customary limit and maximum <u>allowed amount</u> , premiums, balance billed charges, and non-covered charges.				Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <u>network provider</u>?	Yes. For medical: HealthLink. See www.healthlink.com or call 1-800-624-2356 for a list of network providers. For prescription drugs: Elixir. See www.elixirsolutions.com or call 1-800-361-4542.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Open Access Ill Providers	Network	Non-Network	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge after deductible	20% co-insurance	50% co-insurance	_____none_____
	<u>Specialist</u> visit	No charge after deductible	20% co-insurance	50% co-insurance	_____none_____
	<u>Preventive care/screening/immunization</u>	No charge, deductible waived	No charge, deductible waived	50% co-insurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Be Well Clinic No Charge All Other No charge after deductible	20% co-insurance	50% co-insurance	_____none_____
	Imaging (CT/PET scans, MRIs)	Specific Facilities* \$500 co-payment All Other No charge after deductible	20% co-insurance	50% co-insurance	Specific facilities* Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic Hannibal and Quincy, Blessing Physician Services, Quincy Medical Group, (does not apply to emergency, maternity, or physician office services). Pre-certification is required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Open Access III Providers	Network	Non-Network	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.elixirsolutions.com	Generic drugs	25% co-payment	25% co-payment	Not Covered	Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u> , log into your account at www.elixirsolutions.com . Specialty drug <u>co-payments</u> are subject to \$2,500 <u>out-of-pocket limit</u> , per calendar year.
	Preferred brand drugs	25% co-payment	25% co-payment	Not Covered	
	Non-preferred brand drugs	25% co-payment	25% co-payment	Not Covered	
	<u>Specialty drugs</u>	25% co-payment	25% co-payment	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Specific Facilities* \$500 co-payment All Other No charge after deductible	20% co-insurance	50% co-insurance	Specific facilities* Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic Hannibal and Quincy, Blessing Physician Services, Quincy Medical Group, and Northeast MO Ambulatory Surgery Center (does not apply to emergency, maternity, or physician office services). Pre-certification is required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
	Physician/surgeon fees	No charge after deductible	20% co-insurance	50% co-insurance	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	No charge after deductible	No charge after deductible	No charge after deductible	_____none_____
	<u>Emergency medical transportation</u>	No charge after deductible	No charge after deductible	No charge after deductible	_____none_____
	<u>Urgent care</u>	No charge after deductible	20% co-insurance	50% co-insurance	Retail clinics are covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	Specific Facilities* \$500 co-payment All Other No charge after deductible	20% co-insurance	50% co-insurance	Specific facilities* Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic Hannibal and Quincy, Blessing Physician Services, Quincy Medical Group, and Northeast MO Ambulatory Surgery Center (does not apply to emergency, maternity, or physician office services). Pre-certification is required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
	Physician/surgeon fees	No charge after	20% co-	50% co-	_____none_____

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Open Access III Providers	Network	Non-Network	
		deductible	insurance	insurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible	20% co-insurance	50% co-insurance	_____none_____
	Inpatient services	Specific Facilities* \$500 co-payment All Other No charge after deductible	20% co-insurance	50% co-insurance	Specific facilities* Hannibal Regional and Blessing Hospital (does not apply to emergency, maternity, or physician office services). Pre-certification is required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
If you are pregnant	Office visits	No charge after deductible	20% co-insurance	50% co-insurance	Dependent daughter maternity is not covered. Cost-sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere described in the SBC (i.e. ultrasound). Pre-certification is required for a length of stay longer than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean delivery. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
	Childbirth/delivery professional services	No charge after deductible	20% co-insurance	50% co-insurance	
	Childbirth/delivery facility services	No charge after deductible	20% co-insurance	50% co-insurance	
If you need help recovering or have other special needs	<u>Home health care</u>	No charge after deductible	20% co-insurance	50% co-insurance	Calendar Year Maximum: One-hundred (100) visits per <u>plan participant</u> . Pre-certification is required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
	<u>Rehabilitation services</u>	No charge after deductible	20% co-insurance	50% co-insurance	Calendar Year Maximum: Ninety (90) visits per <u>plan participant</u> combined for speech, physical, and occupational therapy. Pre-certification is required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
	<u>Habilitation services</u>	No charge after deductible	20% co-insurance	50% co-insurance	Pre-certification is required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
	<u>Skilled nursing care</u>	No charge after deductible	20% co-insurance	50% co-insurance	Must begin within fourteen (14) days of a three (1) day hospital confinement. Calendar Year Maximum: Seventy (70) visits

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Open Access III Providers	Network	Non-Network	
					per <u>plan participant</u> . Pre-certification is required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
	<u>Durable medical equipment</u>	No charge after deductible	20% co-insurance	50% co-insurance	Pre-certification may be required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
	<u>Hospice services</u>	No charge after deductible	20% co-insurance	50% co-insurance	Lifetime Maximum: Seventy (70) days per <u>plan participant</u> . Pre-certification is required. Failure to obtain <u>pre-certification</u> will result in a \$500 penalty.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not Covered	Benefits are only for vision screening as required under the ACA Preventive Care services for children.
	Children's glasses	Not Covered	Not Covered	Not Covered	_____none_____
	Children's dental check-up	Not Covered	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 the cases of rape, incest, or when the life of the mother is endangered)	• Dental Care (adult)	• Non-emergency care when traveling outside the U.S.
• Acupuncture	• Hearing Aids	• Routine Eye Care (Adult)
• Bariatric Surgery	• Infertility Treatment	• Routine Foot Care
• Cosmetic Surgery	• Long-Term Care	• Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care	• Private Duty Nursing	

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 City of Hannibal and Board of Public Works, 320 Broadway, Hannibal, MO 63041, 573-221-0111. 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
1-866-438-0185.

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 1-866-438-0185.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-438-0185.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-438-0185.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-438-0185.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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 cost sharing** 0%
- **Hospital (facility) cost sharing** 0%
- **Other cost sharing** 25%

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	\$0
Coinsurance	\$
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$560

This coverage example assumes 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 cost sharing** 0%
- **Hospital (facility) cost sharing** 0%
- **Other cost sharing** 25%

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	\$0
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

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

- **The plan's overall deductible** \$500
- **Specialist cost sharing** 0%
- **Hospital (facility) cost sharing** 0%
- **Other cost sharing** 25%

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	\$
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$500

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