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?	**Per participant:** $500 network/ $1,250 non-network **Per family:** $1,200 network/ $2,500 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.
Are there services covered before you meet your deductible?	**Yes.** Co-payments for ER Physician services, alternative medicine, ambulance services, colonoscopy, EPHC PCPs, Tier 1 specialists, and City Employee Medical Clinic, Diabetes Care Management program, Health Management programs, hearing aids, diabetic insulin pumps and supplies, oxygen equipment and supplies, preventive care services, hearing exams, sigmoidoscopy, bone density screening, mammograms (diagnostic and preventive), urgent care, and prescription drugs.	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.**	No. You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Per participant:** $2,500 network/ $4,050 non-network **Per family:** $7,500 network/ $12,150 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.
What is not included in the out-of-pocket limit?	Non-covered expenses, charges in excess of reasonable and customary amounts, premiums, 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, deductible waived **All Other Providers** $35 co-payment	50% co-insurance	Co-payments are paid per visit.
	Specialist visit	**Tier 1** $40 co-payment, deductible waived **All Other Providers** $60 co-payment	50% co-insurance	Co-payments are paid per visit.
	Preventive care/screening/ immunization	No charge	50% co-insurance	Refer to the Summary Plan Description, Section III, Schedule of Benefits, for specific age and frequency limits (if applicable). There is a $75 incentive if an employee or spouse receives preventive care services. Refer to your benefits department for further details.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	50% co-insurance	Preventive care service are covered at 100% in-network, deductible waived.
	Imaging (CT/PET scans, MRIs)	**Freestanding Facilities** 10% co-insurance **All Other Facilities** 20% co-insurance	50% co-insurance	——————————none——————————

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.maxor.com.	Generic drugs	**(30 Day Supply)** City Employee Pharmacy $6 co-payment MaxorPlus Pharmacy $25 co-payment **(90 Day Supply)** City Employee Pharmacy $15 co-payment MaxorPlus Pharmacy Not Covered	Non-Network prescription medications are only available in Emergency/After Hours situations Refer to the Medical Plan Document for further details.	Plan Participants will progressively pay higher co-pays for maintenance prescriptions that are filled at MaxorPlus Retail Network Pharmacy versus the City Employee Pharmacy. Diabetic Supplies (Maximum 90-day Supply) - Covered at 100% (no co-payment). Diabetic Medications (Maximum 90-day Supply) - Covered at 100% (no co-payment) if obtained through the City Employee Diabetes Ten City Challenge Pharmacy Program. Please refer to your Summary Plan Description for information regarding Step Therapy and Cardiovascular Incentive Programs. Chronic Condition Management – The co-payment is waived for generic maintenance prescriptions used to treat chronic conditions such as Asthma, Coronary Artery Disease, COPD, Diabetes, Hypertension, and GERD if filled at the City Employee Pharmacy while enrolled in the disease management program. **Some medications may be subject to quantity limitations and/or pre-certification.** Refer to the Summary Plan Description, Pharmacy Benefit Management Program for specific limits (if applicable). Certain preventive medications (including contraceptives) received by a network pharmacy are covered at 100% and the deductible/co-payment (if applicable) is waived. This does not include non-preferred preventive medications. $2,500 out-of-pocket maximum per member, per year. Includes injectable prescription medications. Specialty drugs and injectables are only available through Maxor Solutions. 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.
	Preferred brand drugs	**(30 Day Supply)** City Employee Pharmacy $35 co-payment MaxorPlus Pharmacy $55 co-payment **(90 Day Supply)** City Employee Pharmacy $70 co-payment MaxorPlus Pharmacy Not Covered		

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.maxor.com.	Non-preferred brand drugs	**(30 Day Supply)** City Employee Pharmacy $60 co-payment MaxorPlus Pharmacy $75 co-payment **(90 Day Supply)** City Employee Pharmacy $120 co-payment MaxorPlus Pharmacy Not Covered		Plan Participants will progressively pay higher co-pays for maintenance prescriptions that are filled at MaxorPlus Retail Network Pharmacy versus the City Employee Pharmacy. Diabetic Supplies (Maximum 90-day Supply) - Covered at 100% (no co-payment). Diabetic Medications (Maximum 90-day Supply) - Covered at 100% (no co-payment) if obtained through the City Employee Diabetes Ten City Challenge Pharmacy Program. Please refer to your Summary Plan Description for information regarding Step Therapy and Cardiovascular Incentive Programs. Chronic Condition Management – The co-payment is waived for generic maintenance prescriptions used to treat chronic conditions such as Asthma, Coronary Artery Disease, COPD, Diabetes, Hypertension, and GERD if filled at the City Employee Pharmacy while enrolled in the disease management program. **Some medications may be subject to quantity limitations and/or pre-certification.** Refer to the Summary Plan Description, Pharmacy Benefit Management Program for specific limits (if applicable). Certain preventive medications (including contraceptives) received by a network pharmacy are covered at 100% and the deductible/co-payment (if applicable) is waived. This does not include non-preferred preventive medications. $2,500 out-of-pocket maximum per member, per year. Includes injectable prescription medications. Specialty drugs and injectables are only available through Maxor Solutions. 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.
	Specialty drugs	**(30 Day Supply)** **Tier 4** Maxor Specialty Drug 20% co-insurance with a max $100 co-payment* MaxorPlus Retail Pharmacy Not Covered **(30 Day Supply)** **Tier 5** Maxor Specialty Drug 20% co-insurance with a max $150 co-payment* MaxorPlus Retail Pharmacy Not Covered **(90 Day Supply)** Not Covered * co-pay will only apply if the member does not have co-pay assistance available.		

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 Facilities** 10% co-insurance **All Other Facilities** 20% co-insurance	50% co-insurance	Anesthesia and radiology fees will be covered as in-network if rendered in an in-network facility.
	Physician/surgeon fees	**UCHealth Memorial Facility** 15% co-insurance **All Other Facilities** 20% co-insurance	50% co-insurance	——————————none——————————
If you need immediate medical attention	Emergency room care	$250 co-payment, deductible waived		**All hospital admissions must be pre-certified within forty-eight (48) hours.** Emergency Physician services are covered 100% deductible waived in-and-out of network. Diagnostic and surgical co-insurance applies.
	Emergency medical transportation	$100 co-payment	$100 co-payment	Deductible is waived in-and-out of network.
	Urgent care	$50 co-payment	50% co-insurance	Deductible is waived in-network. Diagnostic and surgical co-insurance applies.
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.**
	Physician/surgeon fees	20% co-insurance	50% co-insurance	——————————none——————————

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 mental health, behavioral health, or substance abuse services	Outpatient services	**Outpatient** $25 co-payment, deductible waived	50% co-insurance	Includes intensive psychiatric day treatment and partial hospitalization. Drug screenings administered in connection with a Substance Abuse Treatment Program – No charge after deductible. Co-payments are paid per visit. Medicine Monitoring is paid at no charge for in-network and 50% co-insurance after deductible for out-of-network.
	Inpatient services	**UCHealth Memorial Facility** 15% co-insurance **All Other Facilities** 20% co-insurance	50% co-insurance	**Pre-certification is required.**
If you are pregnant	Office visits	**EPHC PCP** $25 co-payment, deductible waived **Tier 1 Specialist** $40 co-payment, deductible waived **All Other Providers** $35 co-payment-PCP $60 co-payment-Specialist	50% co-insurance	**Co-payment on first office visit only.** Cost sharing does not apply for preventative services. Depending on the type of services in-network, a co-payment may apply. Maternity care may include test and series described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	**UCHealth Memorial Facility** 15% co-insurance **All Other Facilities and Hospital Services** 20% co-insurance	50% co-insurance	——————————none——————————
	Childbirth/delivery facility services	**UCHealth Memorial Facility** 15% co-insurance **All Other Facilities and Hospital Services** 20% co-insurance	50% co-insurance	——————————none——————————

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	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 **Inpatient** **UCHealth Memorial Facility** 15% co-insurance **All Other Facilities and Hospital Services** 20% co-insurance	50% co-insurance	Includes speech, physical, and occupational therapy. Outpatient Rehabilitation Services Annual Maximum: limited to 180 annual days per injury and illness combined with cardiac and pulmonary therapy. Inpatient Rehabilitation Services Annual Maximum: sixty (60) visits combined per participant. Pediatric rehabilitation therapy for participants up to age ten (10) limited to sixty (60) combined visits per benefit year. The level of benefits for occupation therapy, physical therapy, or speech therapy shall exceed the limit of sixty (60) visits per benefit year if such therapy is medically necessary to treat autism spectrum disorders. Initial evaluation does not count toward maximums and is paid under the office visit benefit. **Pre-certification is required for pediatric rehabilitation therapy for pediatrics [up to age ten (10).**
	Habilitation services	**Outpatient** $35 co-payment **Inpatient** **UCHealth Memorial Facility** 15% co-insurance **All Other Facilities and Hospital Services** 20% co-insurance	50% co-insurance	——————————none——————————
	Skilled nursing care	50% co-insurance	50% co-insurance	Includes related prescriptions. Lifetime maximum: three hundred sixty-five (365) days. **Pre-Certification is required.**
	Durable medical equipment	0% co-insurance	50% co-insurance	Excludes oxygen and related equipment and supplies. Rental is paid up to allowable purchase price.

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	Hospice services	$150 one-time co-payment	50% co-insurance	Includes inpatient care, physician's services, prescription drugs, home health care series, emotional support services for the patient and the patient's family, bereavement services, and homemaker services.
If your child needs dental or eye care	Children's eye exam	No charge	50% co-insurance	Routine eye examinations for participants to age eighteen (18), when participant is not covered by The COCS Vision Service Plan. Routine eye exam performed by a specialist.
	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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Non-Emergency care when traveling outside the U.S.
- Private-Duty Nursing
- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Weight Loss Programs

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 at The City of Colorado Springs, 30 S. Nevada Avenue, P.O. Box 1575, Mail Code 720, 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 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
E-mail: custserv@ameriben.com
Customer Service: 1-866-955-1482 Fax: 208-424-0595

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 1-866-955-1482.

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.

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	$700
Copayments	$20
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,630**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
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 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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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