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 Ames Construction Inc. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.amesconstruction.com/employee-resources.cfm or call 1-800-453-4302 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** person / **$200** family network **$250** person / **$500** family out-of-network Doesn't apply to preventive care.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. 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 services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. Lab and x-ray, inpatient hospital, outpatient services, and out-of-network well child and immunizations.	You must pay all of the costs for these services up to the specific deductible amounts before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For participating providers $1,500 person / $3,000 family in-network or out-of-network (combined)	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?	Premiums, balance-billed charges, and health care this plan doesn't cover. Penalties for failure to obtain pre-authorization for services.	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. For a list of **preferred providers**, see www.azfmc.com or call 1-800-624-4277 (AZ); www.cofinity.net or call 1-800-831-1166 (CO); www.healtheos.com or call 1-800-279-9776 (WI); www.preferredone.com or call 1-800-451-9597 (MN); 1-877-542-1912 (MT); www.selecthealth.org (UT); or www.multiplan.com or call 1-888-342-7427 (all other states)	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 **copay** 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)	Out-of-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	0% coinsurance $25 copay/visit	25% coinsurance $0 copay/visit	If due to an Accident, first $500 paid at 100%.
	Specialist visit	0% coinsurance $25 copay/visit	25% coinsurance $0 copay/visit	---none---
	Other practitioner office visit	0% coinsurance $25 copay/visit	25% coinsurance $0 copay/visit	---none---
	Preventive care/screening/ Immunization	0% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	---none---
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance $0 copay/ procedure	25% coinsurance $0 copay/ procedure	---none---
	Imaging (CT/PET scans, MRIs)	15% coinsurance $0 copay/ procedure	25% coinsurance $0 copay/ procedure	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or by calling 1-877-860-6415.	Generic drugs	0% coinsurance for retail or mail order $10 copay/ prescription for retail or mail order	Not Covered	Retail limited to a 30-day supply. Mail order limited to a 90-day supply. Copayment counts toward the out-of-pocket limit.
	Preferred brand drugs	0% coinsurance for retail or mail order $15 copay/ prescription for retail or mail order	Not Covered	Retail limited to a 30-day supply. Mail order limited to a 90-day supply. Copayment counts toward the out-of-pocket limit.
	Non-preferred brand drugs	0% coinsurance for retail or mail order $15 copay/ prescription for retail or mail order	Not Covered	Retail limited to a 30-day supply. Mail order limited to a 90-day supply. Copayment counts toward the out-of-pocket limit.
	Specialty drugs	0% coinsurance for retail or mail order $15 copay/ prescription for retail or mail order	Not Covered	Retail limited to a 30-day supply. Mail order limited to a 90-day supply. Copayment counts toward the out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance $0 copay/ procedure	25% coinsurance $0 copay/ procedure	Outpatient surgery deductible waived.

* For more information about limitations and exceptions, see the plan or policy document at http://www.amesconstruction.com/employee-resources.cfm.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	15% coinsurance $0 copay/ procedure	25% coinsurance $0 copay/ procedure	Outpatient surgery deductible waived.
If you need immediate medical attention	Emergency room care	15% coinsurance $60 copay/visit	25% coinsurance $0 copay/visit	---none---
	Emergency medical transportation	15% coinsurance $0 copay/ occurrence	25% coinsurance $0 copay/ occurrence	Accident or medical emergency, to the nearest institution able to treat the condition.
	Urgent care	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance $0 copay/stay	25% coinsurance $0 copay/stay	---none---
	Physician/surgeon fees	15% coinsurance $0 copay/ procedure	25% coinsurance $0 copay/ procedure	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	---none---
	Inpatient services	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	---none---
If you are pregnant	Office visits	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	---none---
	Childbirth/delivery professional services	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	---none---
	Childbirth/delivery facility services	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	---none---
If you need help recovering or have other special health needs	Home health care	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	Coverage is limited to an annual maximum of 100 visits (4 hours = 1 visit).
	Rehabilitation services	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	---none---
	Habilitation services	Not Covered	Not Covered	---none---
	Skilled nursing care	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	Coverage is limited to 60 days per plan year maximum.
	Durable medical equipment	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	Rental up to the purchase price, or purchase price, whichever is less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	---none---
If your child needs dental or eye care	Children's eye exam	15% coinsurance $0 copay/visit	25% coinsurance $0 copay/visit	Preventive eye exams are covered through the age of 18.
	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- 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.)

- Diabetes training
- Chiropractic care
- Hearing aids, if medically necessary, limited to $5,000
- Non-emergency care when traveling outside the U.S.
- Speech therapy, limited to 100 visits

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-453-4302. 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. 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:

- * Your health plan at 1-800-453-4302, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthscarereform

* For more information about limitations and exceptions, see the plan or policy document at http://www.amesconstruction.com/employee-resources.cfm.

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.

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

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, copays and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$100
Specialist copayment	$25
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$100
Copays	$25
Coinsurance	$1,890
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,015**

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

The plan's overall deductible	$100
Specialist copayment	$25
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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
Copays	$25
Coinsurance	$825
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$950**

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

The plan's overall deductible	$100
Specialist copayment	$25
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$100
Copays	$25
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$525**

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