<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$600 person / $1,200 family network and out-of-network</td>
<td>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay.</td>
</tr>
<tr>
<td></td>
<td>Doesn’t apply to preventive care.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. Lab and x-ray, inpatient hospital, outpatient services, and out-of-network well child and immunizations.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For participating providers $2,000 person / $4,000 family in-network or out-of-network (combined)</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover. Penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [http://www.amesconstruction.com/employee-resources.cfm](http://www.amesconstruction.com/employee-resources.cfm).
## Summary of Benefits and Coverage

### What this Plan Covers & What You Pay For Covered Services

**Coverage Period:** 01/01/2021 to 12/31/2021

**Coverage for:** Employee, Family | **Plan Type:** PPO

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### 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.

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## Summary of Benefits and Coverage

### What this Plan Covers & What You Pay For Covered Services

**Coverage Period:** 01/01/2021 to 12/31/2021  
**Coverage for:** Employee, Family | **Plan Type:** PPO

### Ames Construction Inc. – Basic Plan

#### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Primary care visit to treat an injury or illness | Network Provider (You will pay the least): 15% coinsurance $0 copay/visit  
Out-of-Network Provider (You will pay the most): 25% coinsurance $0 copay/visit | If due to an Accident, first $500 paid at 100%. |
| Specialist visit | 15% coinsurance $0 copay/visit  
25% coinsurance $0 copay/visit | ---none--- |
| Other practitioner office visit | 15% coinsurance $0 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/visit  
25% coinsurance $0 copay/visit | ---none--- |
| Imaging (CT/PET scans, MRIs) | 15% coinsurance $0 copay/visit  
25% coinsurance $0 copay/visit | ---none--- |
| **If you need drugs to treat your illness or condition** |
| Generic drugs | 0% coinsurance for retail or mail order  
$15 copay/ prescription for retail or mail order | Not Covered |
| Preferred brand drugs | 0% coinsurance for retail or mail order  
$20 copay/ prescription for retail or mail order | Not Covered |
| Non-preferred brand drugs | 0% coinsurance for retail or mail order  
$20 copay/ prescription for retail or mail order | Not Covered |

*For more information about limitations and exceptions, see the plan or policy document at [http://www.amesconstruction.com/employee-resources.cfm](http://www.amesconstruction.com/employee-resources.cfm).*
## Summary of Benefits and Coverage

**Ames Construction Inc. – Basic Plan**

**Coverage Period:** 01/01/2021 to 12/31/2021

**Coverage for:** Employee, Family | **Plan Type:** PPO

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### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialty drugs</strong></td>
<td>0% coinsurance for retail or mail order, $20 copay/ prescription for retail or mail order</td>
<td>Not Covered</td>
<td>Retail limited to a 30-day supply. Mail order limited to a 90-day supply. Copayment counts toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center) 15% coinsurance, $0 copay/ procedure</td>
<td>25% coinsurance, $0 copay/ procedure</td>
<td>Outpatient surgery deductible waived.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees 15% coinsurance, $0 copay/ procedure</td>
<td>25% coinsurance, $0 copay/ procedure</td>
<td>Outpatient surgery deductible waived.</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care 15% coinsurance, $0 copay/ visit</td>
<td>25% coinsurance, $0 copay/ visit</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation 15% coinsurance, $0 copay/ occurrence</td>
<td>25% coinsurance, $0 copay/ occurrence</td>
<td>Accident or medical emergency, to the nearest institution able to treat the condition.</td>
</tr>
<tr>
<td></td>
<td>Urgent care 15% coinsurance, $0 copay/ visit</td>
<td>25% coinsurance, $0 copay/ visit</td>
<td>---none---</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room) 15% coinsurance, $0 copay/ stay</td>
<td>25% coinsurance, $0 copay/ stay</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees 15% coinsurance, $0 copay/ procedure</td>
<td>25% coinsurance, $0 copay/ procedure</td>
<td>---none---</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services 15% coinsurance, $0 copay/ visit</td>
<td>25% coinsurance, $0 copay/ visit</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Inpatient services 15% coinsurance, $0 copay/ visit</td>
<td>25% coinsurance, $0 copay/ visit</td>
<td>---none---</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits 15% coinsurance, $0 copay/ visit</td>
<td>25% coinsurance, $0 copay/ visit</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services 15% coinsurance, $0 copay/ visit</td>
<td>25% coinsurance, $0 copay/ visit</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services 15% coinsurance, $0 copay/ visit</td>
<td>25% coinsurance, $0 copay/ visit</td>
<td>---none---</td>
</tr>
</tbody>
</table>

---

*For more information about limitations and exceptions, see the plan or policy document at [http://www.amesconstruction.com/employee-resources.cfm](http://www.amesconstruction.com/employee-resources.cfm).*
**Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
--- | --- | --- | --- |
**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). ---none--- |
| 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. Rental up to the purchase price, or purchase price, whichever is less. ---none--- |
| Durable medical equipment | 15% **coinsurance** $0 **copay/visit** | 25% **coinsurance** $0 **copay/visit** | ---none--- |
| 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. ---none--- |
| 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

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

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 plans.

### Peg is Having a Baby
- **(9 months of in-network pre-natal care and a hospital delivery)**
  - The plan's overall deductible: $600
  - Specialist copayment: $0
  - 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,815</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0

**The total Peg would pay is:** $2,415

### Managing Joe's type 2 Diabetes
- **(a year of routine in-network care of a well-controlled condition)**
  - The plan's overall deductible: $600
  - Specialist copayment: $0
  - 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$750</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0

**The total Joe would pay is:** $1,350

### Mia's Simple Fracture
- **(in-network emergency room visit and follow up care)**
  - The plan's overall deductible: $600
  - Specialist copayment: $0
  - 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$330</td>
</tr>
</tbody>
</table>

What isn't covered:
- Limits or exclusions: $0

**The total Mia would pay is:** $930

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