




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, call 1-866-248-7204 or visit www.ebms.com. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,000 per individual and \$2,000 per family Each JULY* a new deductible amount is required.	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. Primary care physician office visits, substance abuse treatment, preventive care services and generic prescription drug are covered before you meet your deductible .	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?	Yes. \$25 additional deductible for the non-emergency use of the emergency room (between hours of 8 am through 5 pm on weekdays).	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$3,000 per individual and \$6,000 per family	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 ?	Prescription drug discounts or coupons, premiums , balance-billing charges (unless balanced billing is prohibited), amounts over the allowable charge, and health care this plan doesn't cover.	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. See www.ebms.com or call 1-866-248-7204 for a list of network providers .	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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copayment /visit; deductible does not apply	Office visit copayment applies only to the office visit. Lab work, x-ray and diagnostic services will be payable subject to deductible and coinsurance .
	Specialist visit	30% coinsurance	None
	Preventive care/screening/immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ebms.com	Generic drugs	30% coinsurance (retail pharmacy), No charge (miRx pharmacy)	Limited to a 90-day supply per prescription (through retail pharmacy and miRx pharmacy)
	Preferred brand drugs	30% coinsurance (retail pharmacy and miRx pharmacy)	
	Non-preferred brand drugs	30% coinsurance (retail pharmacy and miRx pharmacy)	
	Specialty drugs	30% coinsurance (specialty pharmacy)	Limited to a 30-day supply per prescription through Specialty pharmacy only. Contact Navitus Health Solutions toll-free at 1 (866) 333-2757 for more information.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Certain outpatient surgical procedures: 0% coinsurance after deductible All other outpatient surgical procedures: 30% coinsurance after deductible	Contact the Claims Administrator, EBMS, at 1-(866) 248-7204 for a list of certain outpatient surgical procedures that will be paid at 100% after the deductible has been met.
	Physician/surgeon fees	Certain outpatient surgical procedures: 0% coinsurance after deductible All other outpatient surgical procedures: 30% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	30% coinsurance	A separate \$25 deductible will apply for non-emergency use of an emergency room during the following time: 8 a.m. to 5 p.m. weekdays.
	Emergency medical transportation	30% coinsurance	None
	Urgent care	\$25 copayment /visit; deductible does not apply	The urgent care office visit copayment applies only to the urgent care office visit. Lab work, x-ray and diagnostic services will be payable subject to deductible and coinsurance .
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance and \$300 copayment per admission	Limited to the facility's semi-private room rate. Pre-notification of inpatient hospital admissions is strongly recommended.
	Physician/surgeon fees	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental health outpatient services	30% coinsurance	Mental health and substance abuse treatment office visits will be payable subject to the primary care physician office visit benefit.
	Substance abuse treatment outpatient services	30% coinsurance , deductible does not apply	
	Mental health inpatient services Substance abuse treatment inpatient services	30% coinsurance and \$300 copayment per admission 30% coinsurance , deductible does not apply and \$300 copayment per admission	Pre-notification of inpatient hospital admissions is strongly recommended.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	\$25 copayment per visit, deductible does not apply	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Facility charges will be limited to the facility's semi-private room rate.
	Childbirth/delivery facility services	30% coinsurance and \$300 copayment per admission	Limited to 40 visits maximum per plan year (July 1 st – June 30 th). Pre-notification of home health care is strongly recommended.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Pre-notification of inpatient hospital admissions is strongly recommended.
	Rehabilitation services	Outpatient services: 30% coinsurance Inpatient services: 30% coinsurance and \$300 copayment per admission	None
	Habilitation services	Outpatient services: 30% coinsurance Inpatient services: 30% coinsurance and \$300 copayment per admission	Limited to the facility's semi-private room rate. Limited to 120 days maximum per plan year (July 1 st – June 30 th). Pre-notification of inpatient hospital admissions is strongly recommended.
	Skilled nursing care	30% coinsurance and \$300 copayment per admission	Pre-notification of durable medical equipment over \$2,000 is strongly recommended.
	Durable medical equipment	30% coinsurance	Pre-notification of hospice services is strongly recommended.
	Hospice services	Outpatient services: 30% coinsurance Inpatient services: 30% coinsurance and \$300 copayment per admission	No coverage for routine vision exams
If your child needs dental or eye care	Children's eye exam	Not covered	No coverage for eye glasses
	Children's glasses	Not covered	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Children’s dental check-up	Not covered	No coverage through the medical benefits. Dental coverage requires a separate enrollment election.

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](#).)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care • Hearing Aids | <ul style="list-style-type: none"> • Infertility Treatment • Long Term Care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine Foot Care • Weight Loss Programs |
|---|---|---|

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your [plan](#) document.)

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery | <ul style="list-style-type: none"> • Chiropractic Care | <ul style="list-style-type: none"> • Private Duty Nursing |
|--|---|--|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information, contact **EBMS at 1-800-777-3575** or these agencies: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/ or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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: EBMS at 1-800-777-3575 or the DOL’s Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. Contact your state’s program if available at: <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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 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 1-866-248-7204.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-248-7204.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-248-7204.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-248-7204.

————— *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](#) \$1,000
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Hospital (facility) [copayment**](#) \$300
- Other [coinsurance](#) 30%

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 \$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments**	\$450
Coinsurance	\$1,850
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

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

- The [plan's](#) overall [deductible](#) \$1,000
- Primary care physician [copayment](#) \$25
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$1,000
Copayments	\$300
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$3,055

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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*	\$1,000
Copayments	\$0
Coinsurance	\$580
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,580

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

**Note: This [plan](#) has other [copayments](#) for specific services included in this coverage example. See "If you have a hospital stay" row above.