**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<br><br>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. |
| **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 | |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| **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/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<br><br>Substance abuse treatment outpatient services | 30% coinsurance<br><br>30% coinsurance, deductible does not apply | Mental health and substance abuse treatment office visits will be payable subject to the primary care physician office visit benefit. |
| | Mental health inpatient services<br><br>Substance abuse treatment inpatient services | 30% coinsurance and $300 copayment/admission<br><br>30% coinsurance, deductible does not apply and $300 copayment/admission | Pre-notification of inpatient hospital admissions is strongly recommended. |
| **If you are pregnant** | Office visits | $25 copayment/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 | |
| | Childbirth/delivery facility services | 30% coinsurance and $300 copayment/admission | Facility charges will be limited to the facility's semi-private room rate. |

| 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 | 30% coinsurance | Limited to 40 visits maximum per plan year (July 1st – June 30th). Pre-notification of home health care is strongly recommended. |
| | Rehabilitation services | Outpatient services: 30% coinsurance<br>Inpatient services: 30% coinsurance and $300 copayment/admission | Pre-notification of inpatient hospital admissions is strongly recommended. |
| | Habilitation services | Outpatient services: 30% coinsurance<br>Inpatient services: 30% coinsurance and $300 copayment/admission | None |
| | Skilled nursing care | 30% coinsurance and $300 copayment/admission | Limited to the facility's semi-private room rate. Limited to 120 days maximum per plan year (July 1st – June 30th). Pre-notification of inpatient hospital admissions is strongly recommended. |
| | Durable medical equipment | 30% coinsurance | Pre-notification of durable medical equipment over $2,000 is strongly recommended. |
| | Hospice services | Outpatient services: 30% coinsurance<br>Inpatient services: 30% coinsurance and $300 copayment/admission | Pre-notification of hospice services is strongly recommended. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | No coverage for routine vision exams. |
| | Children's glasses | Not covered | No coverage for eye glasses. |
| | 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.)**

- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)**

- Acupuncture
- Bariatric Surgery
- 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. 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, kwiijigo 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.

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