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 1-866-753-1491 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?	$2,800/covered person or $5,600/family unit. Each **SEPTEMBER** a new deductible amount is required.	Generally you have to 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. miCare health center benefits, HDHP expanded preventative prescription drugs, and Preventive care by a network provider and the first $70 for non-network routine mammograms and non-network well child care examinations 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,800/covered person or $5,600/family unit. Each **SEPTEMBER** a new out-of-pocket limit amount is required.	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-billing charges (unless balanced billing is prohibited), 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 1-866-753-1491 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*
		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	0% coinsurance		Coverage limited to 10 visits/ plan year for chiropractic care and limited to 12 visits/ plan year for acupuncture.
	Specialist visit	0% coinsurance		
	Preventive care/ screening/immunization	No charge	0% coinsurance	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)	0% coinsurance		None
	Imaging (CT/PET scans, MRIs)	0% coinsurance		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ebms.com or call SmithRx at 1-844-454-5201.	Generic drugs	0% coinsurance/prescription (retail and mail order)		Participants are required to pay 100% at the pharmacy until the plan year deductible is paid; except for preventive drugs in which the deductible does not apply. **HDHP Expanded Preventive Drugs** copayments apply to the deductible**.** Prescriptions are subject to medical deductible. Coverage limited to 90-day supply/prescription retail or mail order. Mandatory step therapy program may be applied to some medicines. If a covered person chooses a brand name drug when there is a generic drug alternative the applicable formulary or non-formulary copayment applies plus the difference in cost between the generic and brand name drug.
	Formulary brand name drugs	0% coinsurance/prescription (retail and mail order)		
	Non- formulary brand name drugs	0% /prescription (retail and mail order)		
	Specialty drugs	0% coinsurance/prescription		Limited to 30 days and must be obtained through the Specialty Pharmacy Program; only the first fill will be available at retail. Coverage limited to the participating pharmacy allowable charge at a non-participating pharmacy

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

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)	0% coinsurance		None
	Physician/surgeon fees	0% coinsurance		None
If you need immediate medical attention	Emergency room care	0% coinsurance		None
	Emergency medical transportation	0% coinsurance		
	Urgent care	0% coinsurance		None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance		Pre-notification of certain services is strongly recommended, but not required. When inpatient services are provided in Billings, MT, it is **required** that **Billings Clinic** be utilized in order for benefits to be payable. Limited to semiprivate room rate.
	Physician/surgeon fees	0% coinsurance		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance		None
	Inpatient services	0% coinsurance		Pre-notification of certain services is strongly recommended, but not required. When inpatient services are provided in Billings, MT, it is **required** that **Billings Clinic** be utilized in order for benefits to be payable. Limited to semiprivate room rate.
If you are pregnant	Office visits	0% coinsurance		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). Coverage limited to semiprivate room rate.
	Childbirth/delivery professional services	0% coinsurance		
	Childbirth/delivery facility services	0% coinsurance		

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

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	0% coinsurance		Coverage limited to 180 visits/plan year. Pre-notification of certain services is strongly recommended, but not required.
	Rehabilitation services	0% coinsurance		Pre-notification of certain services is strongly recommended, but not required. When inpatient services are provided in Billings, MT, it is **required** that **Billings Clinic** be utilized in order for benefits to be payable. Limited to semiprivate room rate.
	Habilitation services	0% coinsurance		
	Skilled nursing care	0% coinsurance		Coverage limited to 60 days/plan year. Coverage limited to semiprivate room rate.
	Durable medical equipment	0% coinsurance		Pre-notification for durable medical equipment over $2,000 is strongly recommended, but not required.
	Hospice services	0% coinsurance		Pre-notification of certain services is strongly recommended, but not required.
If your child needs dental or eye care	Children's eye exam	Not covered		Vision coverage is available as a separate election.
	Children's glasses	Not covered		
	Children's dental check-up	Not covered		Dental coverage is available as a separate 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
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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**
- Infertility Treatment

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

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: contact the 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 on how 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: contact EBMS at 1-800-777-3575. Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance -Grants/.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 **1-866-753-1491**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-753-1491**.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码1-866-753-1491**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-753-1491**.

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	**$2,800**
Primary Care Physician coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

The plan's overall deductible	**$2,800**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,820**

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

The plan's overall deductible	**$2,800**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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