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?	$1,500/ covered person or $3,000/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, hospice care, services subject to a copayment, routine mammograms, well child care and the following network provider services: physician services, preventive care, and diagnostic mammograms 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. $150 for prescription drug coverage. There are no other specific deductibles.	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?	$3,500/ covered person or $7,000/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	$35 copayment/visit; deductible does not apply	35% coinsurance	Office visit copayment applies to the office visit and covered services provided during the office visit, except durable medical equipment, prosthetics and orthotics. Coverage limited to 10 visits/plan year for chiropractic care. Coverage limited to 12 visits/plan year for acupuncture.
	Specialist visit	$35 copayment/visit; deductible does not apply	35% coinsurance	
	Preventive care/ screening/immunization	No charge	35% 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) - Facility - Physician	20% coinsurance 20% coinsurance; deductible does not apply	35% coinsurance	None.
	Imaging (CT/PET scans, MRIs) - Facility - Physician	20% coinsurance 20% coinsurance; deductible does not apply	35% 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 Customer Care toll-free at (844) 454-5201.	Generic drugs	$0 copayment/prescription (retail & mail order)		Prescriptions are subject to prescription deductible. Retail limited to 30-day supply/prescription per plan year. Mail order limited to 90-day supply/prescription per plan year.. At select pharmacies a 90-day supply option may be available. 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	$40 copayment/prescription (retail) $80 copayment/prescription (mail order)		
	Non-formulary brand name drugs	60% copayment up to $200/prescription (retail) 60% copayment up to $400/prescription (mail order)		
	Specialty drugs - Formulary drugs	$100 copayment/prescription	Not covered	Specialty drugs limited to a 30 day supply and must be obtained through the Specialty Pharmacy Program; only the first fill will be available at retail.

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)	
	- Non-formulary drugs	$200 copayment/prescription		Coverage limited to the participating pharmacy allowable charge at a non-participating pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	None.
	Physician/surgeon fees	20% coinsurance; deductible does not apply	35% coinsurance	None.
If you need immediate medical attention	Emergency room care	$100 copayment/visit; deductible does not apply		The emergency room services copayment applies to all services rendered during the emergency room visit.
	Emergency medical transportation	20% coinsurance		
	Urgent care	$35 copayment /visit; deductible does not apply	35% coinsurance	Copayment applies to the urgent care visit and covered services provided during the urgent care visit, except durable medical equipment, prosthetics and orthopedic devices/orthotics.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% 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	20% coinsurance;	35% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services - Facility - Physician	20% coinsurance 20% coinsurance; deductible does not apply	35% coinsurance	None
	Inpatient services - Facility - Physician	20% coinsurance 20% coinsurance; deductible does not apply	35% 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.

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 are pregnant	Office visits	$35 copayment /visit; deductible does not apply	35% 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	20% coinsurance; deductible does not apply	35% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	35% coinsurance	Coverage limited to 180 visits/plan year. Pre-notification of certain services is strongly recommended, but not required.
	Rehabilitation services - Inpatient Facility - Inpatient Physician - Outpatient Facility - Outpatient Physician	20% coinsurance 20% coinsurance; deductible does not apply 20% coinsurance 20% coinsurance; deductible does not apply	35% coinsurance	Include occupational, physical, and speech therapies. 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 - Inpatient Facility - Inpatient Physician - Outpatient Facility - Outpatient Physician	20% coinsurance 20% coinsurance; deductible does not apply 20% coinsurance 20% coinsurance; deductible does not apply	35% coinsurance	
	Skilled nursing care - Facility - Physician	20% coinsurance 20% coinsurance; deductible does not apply	35% coinsurance	Coverage limited to 60 days/ plan year. Coverage limited to semiprivate room rate.

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)	
	Durable medical equipment	20% coinsurance	35% coinsurance	Pre-notification for durable medical equipment over $2,000 is strongly recommended, but not required.
	Hospice services	No charge		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 (limited to 12 visits/year)
- Bariatric Surgery
- Chiropractic Care (limited to 10 visits/year)
- Infertility Treatment

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 **1-866-753-1491**.
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** **$1,500**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$1,500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

- **The plan's overall deductible** **$1,500**
- **Primary care physician copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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*	$1,500
Copayments	$0
Coinsurance	$370
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is**	**$1,930**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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

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