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, urgent care, substance abuse treatment, preventive care services, and generic prescription drugs through miRx pharmacy 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?	$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 **All other outpatient surgical procedures:** 30% coinsurance	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 **All other outpatient surgical procedures:** 30% coinsurance	

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	None
	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 Substance abuse treatment outpatient services	30% coinsurance 30%, 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 Substance abuse treatment inpatient services	30% coinsurance and $300 copayment/admission 30%, deductible does not apply	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 Inpatient services: 30% coinsurance and $300 copayment/admission	Pre-notification of inpatient hospital admissions is strongly recommended.
	Habilitation services	Outpatient services: 30% coinsurance Inpatient services: 30% coinsurance and $300 copayment/admission	
	Skilled nursing care	30% coinsurance and $300 copayment/admission	Limited to the facility's semi-private room rate and 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 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 (limited to 20 visits/plan year)
- Hearing aids (Children through age 18 limited to one per ear every 3 years)
- Private Duty Nursing

* 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: 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: 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 1-866-248-7204.
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	$300
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,760**

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
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Hospital (facility) copayment	$300
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	$200
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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%
Hospital (facility) copayment	$300
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	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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