




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 1-866-894-1499 or visit [www.ebms.com](http://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:
<b>What is the overall <u>deductible</u>?</b>	\$2,000 per covered person, \$4,000 per family unit	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Network provider</u> physician office visits, pre-admission testing, routine well newborn nursery care, generic drug charges, and <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	There are no other specific <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$3,500 per covered person, \$6,500 family unit	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>prescription drug</u> discounts or coupons, <u>balance-billing</u> charges (unless balanced billing is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.ebms.com">www.ebms.com</a> or call 1-866-894-1499 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Glacier Medical Associates, Heaven's Peak Healthcare, & Greater Valley Health Center: \$15 <u>copayment</u> /visit; <u>deductible</u> waived  All other network providers: \$35 <u>copayment</u> /visit; <u>deductible</u> waived	30% <u>coinsurance</u>	Only the office visit will apply to the office visit <u>copayment</u> . All other services will be payable per normal <u>Plan</u> provisions.  WellVia Telehealth services will be covered at no charge. Contact WellVia toll-free at 1 (855) 935-5842 or through their website <a href="http://www.wellviasolutions.com">www.wellviasolutions.com</a> for more information regarding a telemedicine consultation visit via phone.
	<u>Specialist visit</u>	30% <u>coinsurance</u>		None
	<u>Preventive care/screening/immunization</u>	No charge	<u>Ages birth through 7 years:</u> No charge; <u>8 years through adult:</u> No charge for the first \$350; thereafter, 30% <u>coinsurance</u> for remainder of benefit year.	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.  A "benefit year" shall mean the period beginning July 1 <sup>st</sup> and ending June 30 <sup>th</sup> .
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>		None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>		
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.ebms.com">www.ebms.com</a> .	Generic drugs	20% <u>coinsurance</u> , <u>deductible</u> waived/prescription		Limited to a 90-day supply (retail pharmacy or miRx mail order pharmacy). For more information, contact EBMS toll-free at 1 (866) 894-1499.
	Brand Name drugs	30% <u>coinsurance</u> /prescription		
	<u>Specialty drugs</u>	30% <u>coinsurance</u> /prescription (specialty pharmacy program applies)		Limited to 30-day supply. For more information regarding <u>specialty drugs</u> , contact Magellan Rx toll-free at 1 (800) 424-7908.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>		None
	Physician/surgeon fees	30% <u>coinsurance</u>		None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	30% <u>coinsurance</u>		None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>		None
	<u>Urgent care</u>	30% <u>coinsurance</u>		None

\* For more information about limitations and exceptions, see the plan or policy document at [www.ebms.com](http://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)	Out-of-Network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>		Limited to the facility's semi-private room rate.
	Physician/surgeon fees	30% <u>coinsurance</u>		None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	30% <u>coinsurance</u>		Only the office visit will apply to the office visit <u>copayment</u> . All other services will be payable per normal <u>plan</u> provisions.
	Office visits: Primary care physician	Glacier Medical Associates, Heaven's Peak Healthcare, & Greater Valley Health Center: \$15 <u>copayment</u> /visit; <u>deductible</u> waived	30% <u>coinsurance</u>	
	Specialist	30% <u>coinsurance</u>		
	Inpatient services	30% <u>coinsurance</u>		
<b>If you are pregnant</b>	Office visits	30% <u>coinsurance</u>		<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). Limited to the facility's semi-private room rate.
	Childbirth/delivery professional services	30% <u>coinsurance</u>		
	Childbirth/delivery facility services	30% <u>coinsurance</u>		
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>		Limited to 100 visits maximum per benefit year. Limited to 4 hours per visit.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>		Limited to 30 visits per benefit year for speech therapy, 30 visits per benefit year for physical therapy and 20 visits per benefit year for occupational therapy.
	<u>Habilitation services</u>	30% <u>coinsurance</u>		Limited to 90 days maximum per benefit year. Limited to the facility's semi-private room rate.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>		None
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>		None
	<u>Hospice services</u>	30% <u>coinsurance</u>		Inpatient services are limited to 30 days maximum per benefit year. Bereavement counseling is limited to 7 visits maximum per benefit year.

\* For more information about limitations and exceptions, see the plan or policy document at [www.ebms.com](http://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)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered		No coverage
	Children's glasses	Not covered		No coverage
	Children's dental check-up	Not covered		No coverage

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Hearing aids (Adult)</li> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>		
<ul style="list-style-type: none"> <li>• Chiropractic care (Limited to 35 visits per benefit year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (Children through age 18 limited to one per ear every 3 years)</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss programs (Limited to \$2,000 lifetime maximum)</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [www.ebms.com](http://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](http://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](http://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](http://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 **1-866-894-1499**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-894-1499**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-866-894-1499**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' **1-866-894-1499**.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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 \$2,000
- Specialist coinsurance 30%
- Hospital (facility) coinsurance 30%
- 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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,560</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,000
- Specialist coinsurance 30%
- 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)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,120</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,000
- 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)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,200</b>