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. 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?	$6,000/ per covered person $12,000/ per family unit Each **SEPTEMBER** 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. Preventive care and Recuro Health Telehealth 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?	$6,000/ per covered person $12,000/ per family unit	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, discounts, coupons, or 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*
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	For more information call the Recuro Health Patient Care Center at (855) 6RECURO, ((855) 673-2876) or access their webpage at www.member.recurohealth.com for additional information.
	Recuro Health Telehealth	$35 consultation fee, no deductible applies	
	Specialist visit	0% coinsurance	
	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)	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 mysmithrx.com or call 1-844-454-5201	Generic drugs	0% coinsurance, no deductible applies	Plan Participants are required to pay 100% at the pharmacy until the calendar year deductible is satisfied. Retail and mail order drugs are available up to a 90-day supply per prescription. Specialty drugs are limited to a 30-day supply per prescription and require prior authorization. Deductible and copayments do not apply to preventive care drugs but may apply to drugs available under the HDHP Expanded List of Preventive Care Drugs
	Preferred brand drugs	0% coinsurance	
	Non-preferred brand drugs	0% coinsurance	
	Specialty drugs	0% coinsurance	
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	None
	Urgent care	0% coinsurance	None

* 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*
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.
	Physician/surgeon fees	0% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Pre-notification of certain services is strongly recommended, but not required.
	Inpatient services	0% coinsurance	
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).
	Childbirth/delivery professional services	0% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Limited to 180 days/ maximum per Plan Year. Pre-notification of certain services is strongly recommended, but not required.
	Rehabilitation services	0% coinsurance	**Inpatient** limited to 60 days/plan year. Pre-notification of inpatient admission is strongly recommended, but not required. **Outpatient** limited to 50 combined visits/plan year for physical, occupational and speech therapy. Limits are waived in the case of an autism spectrum disorder.
	Habilitation services		
	Skilled nursing care	0% coinsurance	Limited to 60/ days plan year
	Durable medical equipment	0% coinsurance	Pre-notification of DME 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	None
	Children's glasses	Not Covered	
	Children's dental check-up	Not Covered	Coverage is available as a separate election.

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

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 (Adult)
- Hearing aids
- Routine eye care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Private-duty nursing

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) 753-1491.

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

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' -(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**	**$6,000**
■ **Specialist 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	$6,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,060**

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

■ **The plan's overall deductible**	**$6,000**
■ **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	$5,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,600**

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

■ **The plan's overall deductible**	**$6,000**
■ **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.