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. 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?	$2,000 per covered person, $4,000 per family unit	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. Network provider physician office visits, pre-admission testing, routine well newborn nursery care, generic drug charges, vision exam & refraction, and preventive care 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?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,500 per covered person, $6,500 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, prescription drug discounts or coupons, 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 1-866-894-1499 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)	Out-of-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	Glacier Medical Associates, Heaven's Peak Healthcare, & Greater Valley Health Center: $15 copayment/visit; deductible waived All other network providers: $35 copayment/visit; deductible waived	30% coinsurance	Only the office visit will apply to the office visit copayment. All other services will be payable per normal Plan provisions. Recuro Health Telehealth services will be payable subject to 0% consultation fee, no deductible applies. Contact Recuro Health toll-free at 1-855-673-2876 or through their website www.member.recurohealth.com for more information regarding a telemedicine consultation visit via phone.
	Specialist visit	30% coinsurance		None
	Preventive care/screening/ immunization	No charge	Ages birth through 7 years: No charge; 8 years through adult: No charge for the first $350; thereafter, 30% coinsurance for remainder of benefit year.	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. A "benefit year" shall mean the period beginning July 1st and ending June 30th.
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	20% coinsurance, deductible 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% coinsurance/prescription		
	Specialty drugs	30% coinsurance/prescription (specialty pharmacy program applies)		Limited to 30-day supply. For more information regarding specialty drugs, contact Magellan Rx toll-free at 1-800-424-7908.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance		None
	Physician/surgeon fees	30% coinsurance		None
If you need immediate medical attention	Emergency room care	30% coinsurance		None
	Emergency medical transportation	30% coinsurance		None
	Urgent care	30% 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*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance		None
	Physician/surgeon fees	30% coinsurance		None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance		Only the office visit will apply to the office visit copayment. All other services will be payable per normal plan provisions.
	Office visits: Primary care physician Specialist	Glacier Medical Associates, Heaven's Peak Healthcare, & Greater Valley Health Center: $15 copayment/visit; deductible waived All other network providers: $35 copayment/visit; deductible waived	30% coinsurance	
		30% coinsurance		
	Inpatient services	30% coinsurance		
If you are pregnant	Office visits	30% 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	30% coinsurance		
	Childbirth/delivery facility services	30% coinsurance		
If you need help recovering or have other special health needs	Home health care	10% coinsurance		Limited to 100 visits maximum per benefit year. Limited to 4 hours per visit.
	Rehabilitation services	30% coinsurance		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.
	Habilitation services	30% coinsurance		
	Skilled nursing care	30% coinsurance		Limited to 90 days maximum per benefit year.
	Durable medical equipment	30% coinsurance		None
	Hospice services	30% coinsurance		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.

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	No charge		Limited to $200 per benefit year.
	Children's glasses	Not covered		No coverage
	Children's dental check-up	Not covered		No coverage

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (Limited to 35 visits per benefit year)
- Hearing aids (Children through age 18 limited to one per ear every 3 years)
- Private-duty nursing
- Routine eye care (Adult) (Exam & refraction, contact lens exam, & any services billed along with an annual exam (excludes hardware): up to $200 per benefit year)
- Weight loss programs (Limited to $2,000 lifetime maximum)

* 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 **1-866-894-1499**.

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, kwiijigo holne' **1-866-894-1499**.

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**	**$2,000**
■ **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,500
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**	**$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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$300
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,120**

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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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