




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 866-673-3471. 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?	\$3,300 per Plan Participant \$6,600 per family unit Each SEPTEMBER 1 a new <u>deductible</u> amount is required.	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> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and <u>services</u> 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific <u>services</u> .
What is the out-of-pocket limit for this plan?	\$3,300 per Plan Participant \$6,600 per family unit Each SEPTEMBER 1 a new <u>out-of-pocket limit</u> is required	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered <u>services</u> . 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.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges (unless <u>balance-billing</u> 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> .
Will you pay less if you use a network provider?	Yes. See www.ebms.com or call 866-673-3471 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>non-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>non-network provider</u> for some <u>services</u> (such as lab work). Check with your <u>provider</u> before you get <u>services</u> .
Do you need a referral to see a specialist?	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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Specialist</u> visit	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	0% <u>coinsurance</u>	You may have to pay for <u>services</u> that aren't <u>preventive</u> . Ask your <u>provider</u> if the <u>services</u> needed are <u>preventive</u> , then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.smithrx.com	Generic drugs	0% <u>coinsurance</u> per prescription		Plan Participants are required to pay 100% at the pharmacy until the plan year <u>deductible</u> is satisfied. Retail and mail order drugs are available up to a 90-day supply per prescription. <u>Specialty drugs</u> are limited to a 30-day supply per prescription and require prior authorization. <u>Deductible</u> and <u>copayments</u> do not apply to <u>preventive care</u> drugs but may apply to drugs available under the HDHP Expanded List of <u>Preventive Care</u> Drugs.
	Preferred brand drugs	0% <u>coinsurance</u> per prescription		
	Non-preferred brand drugs	0% <u>coinsurance</u> per prescription		
	<u>Specialty drugs</u>	0% <u>coinsurance</u> per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	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 need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>		None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>		None
	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Inpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you are pregnant	Office visits	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of <u>services</u> , a <u>copayment</u> may apply. Maternity care may include tests and <u>services</u> described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional <u>services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Childbirth/delivery facility <u>services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Limited to 180 visits per Plan Year
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Habilitation services</u>	See <u>Rehabilitation Services</u> above		
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Limited to 60 days per Plan Year
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Hospice services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	Not Covered		Coverage may be available under a separate election
	Children's glasses	Not Covered		
	Children's dental check-up	Not Covered		Coverage may be available under 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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- 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
- Chiropractic care
- Hearing aids
- Infertility treatment

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: For non-federal government health plans, contact the 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: For non-federal governmental group health plans and church plans that are group health plans 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 866-673-3471

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-673-3471

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 866-673-3471.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 866-673-3471.

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 <u>plan's</u> overall <u>deductible</u>	\$3,300
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,360

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,300
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,320

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,300
■ <u>Specialist coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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.