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 1-866-268-3625 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?	$2,500/person or $5,000/family.	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. Office visits, diagnostic lab and x-ray, colonoscopy/ sigmoidoscopy, allergy injections, routine electron beam tomography, alternative care, naturopathic treatment, urgent care office visits, 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $5,000/person or $10,000 family; for out-of-network providers $10,000/person or $20,000/family. For prescription drug coverage $1,200/person or $3,200 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?	Cost containment penalties, vision services, premiums, 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 1-866-268-3625 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
		Participating Provider (You will pay the least)	Non-Participating 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	$25 copayment/visit; deductible does not apply	20% coinsurance after $25 copayment/visit; deductible does not apply	Office visit copayment applies to the office visit charge only. All other services performed during the office visit are payable per normal plan provisions. Alternative care coverage: includes chiropractic treatment, massage therapy and acupuncture $15 copayment/visit; deductible does not apply, limited to $45/visit and $1,500 combined/year. Diagnostic x-rays ordered by a chiropractor will be payable per normal plan provisions.
	Specialist visit	$25 copayment/visit; deductible does not apply	20% coinsurance after $25 copayment/visit; deductible does not apply	
	Preventive care/screening/ immunization	No charge	20% coinsurance; deductible does not apply	Coverage limited to age and developmentally appropriate frequency limitations. **Note:** Not all routine services may qualify as preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	Inpatient: 20% coinsurance Outpatient: 20% coinsurance; deductible does not apply	Inpatient: 40% coinsurance Outpatient: 40% coinsurance; deductible does not apply	Diagnostic colonoscopy/sigmoidoscopy: if performed at a participating provider: No charge; if performed at a non-participating provider: 20% coinsurance; deductible does not apply
	Imaging (CT/PET scans, MRIs)			
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 copayment/prescription (retail) $40 copayment/prescription (mail order)		Coverage is limited to 34-day supply per retail prescription or available up to a 100-day supply per mail order prescription. Retail prescriptions purchased at a non-participating pharmacy or when the member's ID card is not used must be manually submitted and will be subject to a 50% copayment.
	Formulary brand drugs	Greater of: $50 or 20% up to $100 (retail) Greater of: $100 or 20% up to $200 (mail order)		
	Non-formulary brand drugs	Greater of: $75 or 20% up to $125 (retail) Greater of: $150 or 20% up to $300 (mail order)		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care - Medical Emergency - Non-Medical Emergency	$100 copayment/visit then 20% coinsurance after deductible Not Covered		Pre-notification is required within 2 business days after an admission from the ER to avoid a penalty. Copayment is waived if admitted.
	Emergency medical transportation	20% coinsurance		Coverage limited to 400 miles/condition.
	Urgent care - Facility - Office visit	20% coinsurance $25 copayment/visit; deductible does not apply	40% coinsurance 20% coinsurance after $25 copayment/visit; deductible does not apply	Urgent care office visit copayment applies to the office visit charge only. All other services performed during the office visit are payable per normal plan provisions.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copayment/admission then 20% coinsurance after deductible	$100 copayment/admission then 40% coinsurance after deductible	Pre-notification is required prior to any inpatient admission or within two days after an admission from the Emergency Room to avoid a penalty. If you don't pre-notify for an inpatient admission, benefits could be reduced by $1,000. Coverage limited to the semi-private room rate.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/visit; deductible does not apply	20% coinsurance after $25 copayment/visit; deductible does not apply	None
	Inpatient services	20% coinsurance	40% coinsurance	Pre-notification is required prior to any inpatient admission or within two days after an admission from the Emergency Room to avoid a penalty. If you don't pre-notify for an inpatient admission, benefits could be reduced by $1,000. Coverage limited to the semi-private room rate.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Office visits	$25 copayment/visit; deductible does not apply	20% coinsurance after $25 copayment/visit; deductible does not apply	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). Pre-notification is required for any inpatient maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section to avoid a penalty. Coverage limited to the semi-private room rate.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$100 copayment/admission then 20% coinsurance after deductible	$100 copayment/admission then 40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage limited to 2 visits/day and 180 visits/year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage limited to 30 outpatient visits combined/year. Includes physical therapy, speech therapy, occupational therapy, and vision therapy. Coverage limited to 30 inpatient days/year. Pre-notification is required prior to any inpatient admission to avoid a penalty. If you don't pre-notify for an inpatient admission, benefits could be reduced by $1,000.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage limited to 60 days/year Pre-notification is required prior to any inpatient admission to avoid a penalty. If you don't pre-notify for an inpatient admission, benefits could be reduced by $1,000. Coverage limited to the semi-private room rate.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	Pre-notification is required prior to any inpatient admission to avoid a penalty. If you don't pre-notify for an inpatient admission, benefits could be reduced by $1,000.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge		Coverage limited to one exam/year.
	Children's glasses	No charge		Coverage limited to one set of lenses/frames or a 12-month supply of disposable contact lenses in lieu of glasses/year.
	Children's dental check-up	Not covered		Benefits may be available through a separate plan 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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult) *(Benefits may be available through a separate plan election)*
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information, contact EBMS at 1-800-777-3575 or these agencies: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/ or 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 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 or the DOL's Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. Contact your state's program if available at: http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 1-866-487-2365.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-487-2365.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-487-2365.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-487-2365.

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	$2,500
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$2,500
Copayments*	$205
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is*	**$5,245**

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

The plan's overall deductible	$2,500
Primary care physician copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,755
Copayments*	$1,520
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,335**

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

The plan's overall deductible	$2,500
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$945
Copayments*	$275
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,220**

*Note: This plan has other out-of-pocket limits for specific services included in this coverage example. See " What is the out-of-pocket limit for this plan?" row above. This plan has additional copayments for hospital admission and emergency room services.

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