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 1-866-536-3543 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?	$500/Individual or $1,500/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. Preventive care, Chiropractic services (not including x-rays), Diabetic Education (the first $250) Hospice, Tobacco Cessation Counseling (3 visits per Calendar Year) and second surgical opinions 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.
Are there other deductibles for specific services?	Yes. $25 Dental/Individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$2,000 Individual / $6,000 Family for medical; $1,650 Individual / $3,300 Family for prescription drugs.	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 the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Dental services, copayments, 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. www.ebms.com or call 1-866-536-3543 for a list of network providers. For a list of network pharmacies, see www.mp.medimpact.com or call 1-844-336-2680	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	20% coinsurance	30% coinsurance	None
	Specialist visit (other practitioner office visits including acupuncture and chiropractic specialists)	20% coinsurance	30% coinsurance	Deductible does not apply for chiropractic services; coverage is limited to $30 per visit for chiropractic services, excluding x-rays.
	Preventive care/screening/ immunization	No charge	No charge	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)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Medimpact.com or by phone at 1-844-336-2680	Generic drugs (Tier 1)	$15 copayment/prescription retail $30 copayment/prescription mail order		Certain preventive medications have a first dollar Benefit. Call MedImpact for applicable medications and copay information at 1-866-536-3543 Covers up to a 30-day supply per prescription (retail prescription); 90-day supply per prescription (mail order prescription). Specialty drugs are limited to a 30-day supply and can only be filled through MedImpact Direct Specialty Pharmacy Program available at www.Medimpactdirect.com or by the specialty number 1-877-391-1103.
	Preferred brand drugs (Tier 2)	$40 copayment/ prescription retail $80 copayment/ prescription mail order		
	Non-preferred brand drugs (Tier 3)	50% coinsurance / prescription retail & mail order		
	Specialty drugs (Tier 4)	$150 copayment/ prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	60% coinsurance	None

If you need immediate medical attention	Emergency room care	20% coinsurance	60% coinsurance	None
	Emergency medical transportation	20% coinsurance	60% coinsurance	None
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Limited to the semi-private room rate.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance		None
	Inpatient services	20% coinsurance		Limited to the semi-private room rate..
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Limited to the semi-private room rate.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Deductible	60% coinsurance (subject to balance billing)	Coverage limited to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance	30% coinsurance	None
	Habilitation services	20% coinsurance	30% coinsurance	Coverage for Applied Behavioral Analysis (ABA) therapy for Autism Spectrum Disorder is limited to covered persons up to age 19.
	Skilled nursing care	20% coinsurance	60% coinsurance	Coverage limited to 90 days per calendar year
	Durable medical equipment	20% coinsurance	60% coinsurance	Preauthorization from the Plan is recommended for the original purchase or replacement of durable medical equipment over $2,000. Please refer to the Preauthorization section of the Plan.
	Hospice services	0% coinsurance	0% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	$25 deductible, 20% coinsurance		Limited to two exams per calendar year.

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
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care (without co-morbidities)
- 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
- Dental 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. 1-866-356-3543.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-356-3543.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-356-3543.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-356-3543.

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	$500
Specialist coinsurance	$0
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*	$500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,060

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

The plan's overall deductible	$500
Primary care physician copayment	$0
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*	$1,497
Copayments	$280
Coinsurance	$223
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,000

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

The plan's overall deductible	$500
Specialist copayment	$0
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*	$500
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$885

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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