



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 1-866-268-3622 or visit [www.ebms.com](http://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 <u>deductible</u> ?	\$3,200 per covered person \$6,400 per family unit	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 <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<b>Medical:</b> \$3,200 per covered person or \$6,400 per family unit. <b>Prescription drugs:</b> \$1,450 per covered person or \$2,900 per family unit.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. 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 <u>out-of-pocket limit</u> ?	<u>Prescription drug</u> expenses (maximum out-of-pocket, <u>coinsurance</u> , <u>copayments</u> , discounts or coupons), <u>premiums</u> , <u>balance-billing</u> charges, (unless balanced billing is prohibited), amounts over allowable claim limits, 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 <u>network provider</u> ?	Yes. See <a href="http://www.ebms.com">www.ebms.com</a> or call 1-866-268-3622 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider 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>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	0% <u>coinsurance</u> , after <u>deductible</u>		Alternative care (includes acupuncture, acupressure, massage therapy, and spinal manipulation/chiropractic services) is limited to \$750 combined per calendar year.
	<u>Specialist</u> visit	0% <u>coinsurance</u> , after <u>deductible</u>		
	HealthJoy Telemedicine	\$25 <u>copayment</u>		<u>Copayment</u> may be waived if permitted under applicable law. Call HealthJoy toll-free at (877) 500-3212 or (855) 947-6900, or access their webpage at <a href="http://www.HealthJoy.com">www.HealthJoy.com</a> for additional information.
	<u>Preventive care/ screening/ immunization</u>	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 <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u> , after <u>deductible</u>		None
	Imaging (CT/PET scans, MRIs)			
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.mysmithrx.com">www.mysmithrx.com</a> or by calling Smith Rx toll-free (844) 512-3030	Generic drugs	1-30-day supply (retail/mail order): \$10 <u>copayment</u> /prescription 31-90-day supply (retail/mail order): \$20 <u>copayment</u> /prescription	30-day supply: 50% <u>coinsurance</u>	<u>Copayment</u> applies after the medical <u>deductible</u> of this <u>plan</u> is met.  <b>Dispense as written penalty:</b> If a brand name drug is requested by the covered person instead of a generic drug (and a generic drug is available), the covered person will be responsible for the difference in cost (between generic and applicable brand name drug) in addition to the applicable brand name drug <u>copayment</u> .
	Preferred brand drugs	1-30-day supply (retail/mail order): \$25 <u>copayment</u> /prescription 31-90-day supply (retail/mail order): \$50 <u>copayment</u> /prescription		
	Non-preferred brand drugs	1-30-day supply (retail/mail order): \$50 <u>copayment</u> /prescription 31-90-day supply (retail/mail order): \$100 <u>copayment</u> /prescription		
	<u>Specialty drugs</u>	\$100 <u>copayment</u> /prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u> , after <u>deductible</u>		Pre-certification of an outpatient surgical procedure is required prior to service.
	Physician/surgeon fees	0% <u>coinsurance</u> , after <u>deductible</u>		None
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u> , after <u>deductible</u>		Pre-certification of an inpatient admission from the Emergency Room is required.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u> , after <u>deductible</u>		None
	<u>Urgent care</u>	0% <u>coinsurance</u> , after <u>deductible</u>		None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u> , after <u>deductible</u>		Pre-certification of an inpatient admission is required prior to service.
	Physician/surgeon fees	0% <u>coinsurance</u> , after <u>deductible</u>		None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u> , after <u>deductible</u>		None
	Inpatient services	0% <u>coinsurance</u> , after <u>deductible</u>		Pre-certification of an inpatient admission is required prior to service.
If you are pregnant	Office visits	0% <u>coinsurance</u> , after <u>deductible</u>		<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	0% <u>coinsurance</u> , after <u>deductible</u>		
	Childbirth/delivery facility services	0% <u>coinsurance</u> , after <u>deductible</u>		Pre-certification of a routine maternity admission that exceeds 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	0% <u>coinsurance</u> , after <u>deductible</u>		Coverage is limited to 180 visits/calendar year. Pre-certification is required prior to service.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u> , after <u>deductible</u>		Inpatient Rehabilitation therapy is limited to 30 days/calendar year.
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	0% <u>coinsurance</u> , after <u>deductible</u>		Coverage is limited to 60 days/calendar year. Pre-certification is required prior to service.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u> , after <u>deductible</u>		Pre-certification of DME over \$2,000 is required.
	<u>Hospice services</u>	0% <u>coinsurance</u> , after <u>deductible</u>		Coverage is limited to up to 6 months per calendar year. Pre-certification is required prior to service.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered		Vision coverage may be available as a separate election.
	Children's glasses	Not covered		
	Children's dental check-up	No charge		Up to age 19, coverage is limited to 2 exams and cleanings per calendar year.

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (\$750 calendar year maximum, combined with acupressure, massage therapy and spinal manipulation/chiropractic services)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (\$750 calendar year maximum, combined with acupuncture, acupressure and massage therapy)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult) (\$100/calendar year)</li> </ul>

**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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthcarereform](http://www.dol.gov/ebsa/healthcarereform). 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](http://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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthcarereform](http://www.dol.gov/ebsa/healthcarereform). 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.**

[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 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 **1-866-268-3622**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-268-3622**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-866-268-3622**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' **1-866-268-3622**.

*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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,200
■ <a href="#">Specialist coinsurance</a>	0%	■ Primary care physician <a href="#">coinsurance</a>	0%	■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	0%	■ Hospital (facility) <a href="#">coinsurance</a>	0%	■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%
This EXAMPLE event includes services like: <a href="#">Specialist</a> office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <a href="#">Diagnostic tests</a> ( <i>ultrasounds and blood work</i> ) <a href="#">Specialist</a> visit ( <i>anesthesia</i> )		This EXAMPLE event includes services like: <a href="#">Primary care physician</a> office visits ( <i>including disease education</i> ) <a href="#">Diagnostic tests</a> ( <i>blood work</i> ) Prescription drugs <a href="#">Durable medical equipment</a> ( <i>glucose meter</i> )		This EXAMPLE event includes services like: <a href="#">Emergency room care</a> ( <i>including medical supplies</i> ) <a href="#">Diagnostic test</a> ( <i>x-ray</i> ) <a href="#">Durable medical equipment</a> ( <i>crutches</i> ) <a href="#">Rehabilitation services</a> ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$3,200	Deductibles	\$3,200	Deductibles	\$2,800
Copayments	\$10	Copayments	\$200	Copayments	\$0
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,300</b>	<b>The total Joe would pay is</b>	<b>\$3,400</b>	<b>The total Mia would pay is</b>	<b>\$2,800</b>