



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. 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>?	\$2,600 per covered person \$5,200 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. HealthJoy telemedicine, <u>prescription drugs</u> , non-routine colonoscopies up to \$1,200 per calendar year, <u>network providers physician services</u> , <u>hospice care</u> , alternative care, and <u>preventive care</u> 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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>?	Medical: \$5,500 per covered person or \$10,500 per family unit. Prescription drugs: \$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 the 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 www.ebms.com or call 1-866-268-3622 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>out-of-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>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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% <u>coinsurance</u> /visit, <u>deductible</u> does not apply	60% <u>coinsurance</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	50% <u>coinsurance</u> /visit, <u>deductible</u> does not apply	60% <u>coinsurance</u>	
	HealthJoy Telemedicine	No charge		Call HealthJoy toll-free at (877) 500-3212 or (855) 947-6900, or access their webpage at www.HealthJoy.com for additional information.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	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.
If you have a test	<u>Diagnostic test</u> (x-ray/blood work) Facility	50% <u>coinsurance</u>	60% <u>coinsurance</u>	None
	Physician	50% <u>coinsurance</u> , <u>deductible</u> does not apply		
	Imaging (CT/PET scans, MRIs) Facility	50% <u>coinsurance</u>		
	Physician	50% <u>coinsurance</u> , <u>deductible</u> does not apply		

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 need drugs to treat your illness or condition More information about prescription drug coverage at www.mysmithrx.com or by calling Smith Rx toll-free at (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>Deductible</u> does not apply to prescription drugs. Dispense as written penalty: 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	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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Pre-certification of an outpatient surgical procedure is required prior to service.
	Physician/surgeon fees	50% <u>coinsurance</u> , <u>deductible</u> does not apply	60% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u>		Pre-certification of an inpatient admission from the emergency room is required.
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>		None
	<u>Urgent care</u>	50% <u>coinsurance</u> , <u>deductible</u> does not apply	60% <u>coinsurance</u>	None
Facility Physician				

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 a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Pre-certification of an inpatient admission is required prior to service.
	Physician/surgeon fees	50% <u>coinsurance</u> , <u>deductible</u> does not apply	60% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services Facility Office visit	50% <u>coinsurance</u>	60% <u>coinsurance</u>	None
		50% <u>coinsurance</u> , <u>deductible</u> does not apply		
	Inpatient services Facility Physician	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Pre-certification of an inpatient admission is required prior to service.
		50% <u>coinsurance</u> , <u>deductible</u> does not apply		
If you are pregnant	Office visits	50% <u>coinsurance</u> , <u>deductible</u> does not apply	60% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound). 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.
	Childbirth/delivery professional services	50% <u>coinsurance</u> , <u>deductible</u> does not apply	60% <u>coinsurance</u>	
	Childbirth/delivery facility services	50% <u>coinsurance</u>	60% <u>coinsurance</u>	

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 need help recovering or have other special health needs	<u>Home health care</u>	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Limited to 180 visits per calendar year. Pre-certification is required prior to service.	
	<u>Rehabilitation services</u> Facility Physician	50% <u>coinsurance</u>	60% <u>coinsurance</u>	Inpatient rehabilitation therapy is limited to 30 days per calendar year.	
		50% <u>coinsurance</u> , <u>deductible</u> does not apply			
	<u>Habilitation services</u> Facility Physician	50% <u>coinsurance</u>			
		50% <u>coinsurance</u> , <u>deductible</u> does not apply			
	<u>Skilled nursing care</u>	50% <u>coinsurance</u>	60% <u>coinsurance</u>		Coverage is limited to 60 days/calendar year. Pre-certification is required prior to service.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	60% <u>coinsurance</u>		Pre-certification of DME over \$2,000 is required.
<u>Hospice services</u>	No charge	No charge	Coverage is limited to up to 6 months per 3 calendar years. Pre-certification is required prior to service.		
If your child needs dental or eye care	Children's eye exam	Not covered		Vision coverage may be available under a separate election.	
	Children's glasses	Not covered			
	Children's dental check-up	No charge		Up to age 19, coverage is limited to 2 routine exams and cleanings 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.)		
<ul style="list-style-type: none"> Bariatric surgery Cosmetic surgery Hearing aids 	<ul style="list-style-type: none"> Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Acupuncture (\$750 calendar year maximum, combined with acupressure, massage therapy and spinal manipulation/chiropractic services) 	<ul style="list-style-type: none"> Chiropractic care (\$750 calendar year maximum, combined with acupuncture, acupressure and massage therapy) 	<ul style="list-style-type: none"> Dental care (Adult) (\$100/calendar year)

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. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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): Dinekehgo 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 plan's overall deductible	\$2,600	■ The plan's overall deductible	\$2,600	■ The plan's overall deductible	\$2,600
■ Specialist coinsurance	50%	■ Primary care physician coinsurance	50%	■ Specialist coinsurance	50%
■ Hospital (facility) coinsurance	50%	■ Hospital (facility) coinsurance	50%	■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%	■ Other coinsurance	50%	■ Other coinsurance	50%
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
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	\$2,600	Deductibles	\$2,600	Deductibles	\$2,100
Copayments	\$10	Copayments	\$200	Copayments	\$0
Coinsurance	\$5,000	Coinsurance	\$700	Coinsurance	\$400
<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
The total Peg would pay is	\$5,600	The total Joe would pay is	\$3,500	The total Mia would pay is	\$2,500