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 deductible?	$3,200 per covered person $6,400 per family unit	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 services 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?	**Medical:** $3,200 per covered person or $6,400 per family unit. **Prescription drugs:** $1,450 per covered person or $2,900 per family unit.	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?	Prescription drug expenses (maximum out-of-pocket, coinsurance, copayments, discounts or coupons), premiums, balance billing charges (unless balance billing is prohibited), amounts over allowable claim limits, 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 1-866-268-3622 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
		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	0% coinsurance, after deductible		Alternative care (includes acupuncture, acupressure, massage therapy, and spinal manipulation/chiropractic services) is limited to $750 combined per calendar year.
	Specialist visit	0% coinsurance, after deductible		
	HealthJoy Telemedicine	$25 consultation fee		The consultation fee 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 www.HealthJoy.com for additional information.
	Preventive care/ screening/ immunization	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 plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance, after deductible		None
	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.mysmithrx.com or by calling Smith Rx toll-free (844) 454-5201.	Generic drugs	1-30-day supply (retail/mail order): $10 copayment/prescription 31-90-day supply (retail/mail order): $20 copayment/prescription	30-day supply: 50% coinsurance	Copayments applies after the medical deductible of this plan is met. **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 copayment.
	Preferred brand drugs	1-30-day supply (retail/mail order): $25 copayment/prescription 31-90-day supply (retail/mail order): $50 copayment/prescription		
	Non-preferred brand drugs	1-30-day supply (retail/mail order): $50 copayment/prescription 31-90-day supply (retail/mail order): $100 copayment/prescription		
	Specialty drugs	$100 copayment/prescription	Not covered	Limited to a 30-day supply/prescription & requires purchase through the specialty pharmacy program. Only first fill will be eligible through the retail pharmacy.

* 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)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance, after deductible		Pre-certification of an outpatient surgical procedure is required prior to service.
	Physician/surgeon fees	0% coinsurance, after deductible		None
If you need immediate medical attention	Emergency room care	0% coinsurance, after deductible		Pre-certification of an inpatient admission from the Emergency Room is required.
	Emergency medical transportation	0% coinsurance, after deductible		None
	Urgent care	0% coinsurance, after deductible		None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance, after deductible		Pre-certification of an inpatient admission is required prior to service.
	Physician/surgeon fees	0% coinsurance, after deductible		None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance, after deductible		None
	Inpatient services	0% coinsurance, after deductible		Pre-certification of an inpatient admission is required prior to service.
If you are pregnant	Office visits	0% coinsurance, after deductible		Cost sharing does not apply to certain preventive services. 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	0% coinsurance, after deductible		
	Childbirth/delivery facility services	0% coinsurance, after deductible		

* 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)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance, after deductible		Coverage is limited to 180 visits/calendar year. Pre-certification is required prior to service.
	Rehabilitation services	0% coinsurance, after deductible		Inpatient Rehabilitation therapy is limited to 30 days/calendar year.
	Habilitation services			
	Skilled nursing care	0% coinsurance, after deductible		Coverage is limited to 60 days/calendar year. Pre-certification is required prior to service.
	Durable medical equipment	0% coinsurance, after deductible		Pre-certification of DME over $2,000 is required.
	Hospice services	0% coinsurance, after deductible		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 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:

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)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture ($750 calendar year maximum, combined with acupressure, massage therapy and spinal manipulation/chiropractic services)
- Chiropractic care ($750 calendar year maximum, combined with acupuncture, acupressure and massage therapy)
- Dental care (Adult) ($100/calendar year)
- Routine foot care (1 pair custom foot orthotics/calendar year, including impression casting for orthotic appliances, padding, strapping and fabrication)

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-268-3622**.

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	$3,200
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,200
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,270**

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

The plan's overall deductible	$3,200
Primary care physician coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,200
Copayments	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,530**

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

The plan's overall deductible	$3,200
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
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.