




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?	\$500 per covered person \$1,000 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 deductible?	Yes. <u>Prescription drugs</u> , HealthJoy telemedicine & Recuro Health mental telehealth, <u>network providers physician services</u> , non-routine colonoscopies up to \$1,200 per calendar year, <u>hospice services</u> , <u>preventive care</u> , and alternative care 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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Medical: \$3,000 per covered person or \$5,500 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 out-of-pocket limit?	<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 <u>balance billing</u> 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 network provider?	Yes. See www.fchn.com or call 1-800-231-6935 or 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</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 referral to see a specialist?	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	40% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <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	40% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	
	HealthJoy Telemedicine	No charge		The consultation fee may be waived if permitted under applicable law. Call HealthJoy toll-free at (855) 947-6900 or access all HealthJoy benefits by downloading the HealthJoy app. For mental health telemedicine only, call Recuro Health toll-free at (855) 673-2876 or access their webpage at www.member.recurohealth.com for additional information.
	Recuro Health Mental Telehealth	40% <u>coinsurance</u> , <u>deductible</u> does not apply		
<u>Preventive care/ screening/immunization</u>	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	40% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician	40% <u>coinsurance</u> , <u>deductible</u> does not apply		
	Imaging (CT/PET scans, MRIs) Facility	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Physician	40% <u>coinsurance</u> , <u>deductible</u> does not apply		

* 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 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 <u>copayment</u> /prescription 31-90-day supply (retail/mail order): \$20 <u>copayment</u> /prescription	30-day supply: 50% <u>coinsurance</u>	<u>Deductibles</u> do not apply to all pharmacy benefits. 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 and 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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification of an outpatient surgical procedure is required prior to service.
	Physician/surgeon fees	40% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	40% <u>coinsurance</u>		Pre-certification of an inpatient admission from the emergency room is required.
	<u>Emergency medical transportation</u>	40% <u>coinsurance</u>		None
	<u>Urgent care</u> Facility Physician	40% <u>coinsurance</u> 40% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	None

* 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 a hospital stay	Facility fee (e.g., hospital room)	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification of an inpatient admission is required prior to service.	
	Physician/surgeon fees	40% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>		
If you need mental health, behavioral health, or substance abuse services	Outpatient services Facility Physician	40% <u>coinsurance</u>	50% <u>coinsurance</u>	For mental health telemedicine only, call Recuro Health toll-free at (855) 673-2876 or access their webpage at www.member.recurohealth.com for additional information.	
		40% <u>coinsurance</u> , <u>deductible</u> does not apply			
	Inpatient services Facility Physician	40% <u>coinsurance</u>	50% <u>coinsurance</u>		
		40% <u>coinsurance</u> , <u>deductible</u> does not apply			
If you are pregnant	Office visits	40% <u>coinsurance</u> /visit; <u>deductible</u> does not apply	50% <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	40% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>		
	Childbirth/delivery facility services	40% <u>coinsurance</u>	50% <u>coinsurance</u>		
If you need help recovering or have other special health needs	<u>Home health care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 180 visits per calendar year. Pre-certification is required prior to service.	
	<u>Rehabilitation services</u> Facility Physician	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Inpatient therapy is limited to 30 days per calendar year.	
		40% <u>coinsurance</u> , <u>deductible</u> does not apply			
	<u>Habilitation services</u> Facility Physician	40% <u>coinsurance</u>		40% <u>coinsurance</u> , <u>deductible</u> does not apply	Outpatient rehabilitation includes physical, occupational, speech, or cardiac therapies.
		40% <u>coinsurance</u> , <u>deductible</u> does not apply			

* 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 (continued)	<u>Skilled nursing care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 60 days/calendar year. Pre-certification is required prior to service.
	<u>Durable medical equipment</u>	40% <u>coinsurance</u>	50% <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 and limited to 2 routine exams and cleanings per calendar year.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<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) Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> 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) 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, kwijigo 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)
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|---|---|---|
| <ul style="list-style-type: none"> ■ The plan's overall deductible \$500 ■ Specialist coinsurance 40% ■ Hospital (facility) coinsurance 40% ■ Other coinsurance 40% | <ul style="list-style-type: none"> ■ The plan's overall deductible \$500 ■ Primary care physician coinsurance 40% ■ Hospital (facility) coinsurance 40% ■ Other coinsurance 40% | <ul style="list-style-type: none"> ■ The plan's overall deductible \$500 ■ Specialist coinsurance 40% ■ Hospital (facility) coinsurance 40% ■ Other coinsurance 40% |
|---|---|---|

<p>This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)</p>	<p>This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) Prescription drugs <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>	<p>This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>
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Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
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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	\$500	Deductibles	\$500	Deductibles	\$500
Copayments	\$10	Copayments	\$640	Copayments	\$10
Coinsurance	\$2,500	Coinsurance	\$570	Coinsurance	\$920
<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	\$3,070	The total Joe would pay is	\$1,730	The total Mia would pay is	\$1,430