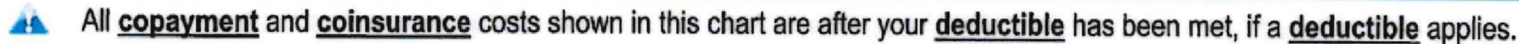
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call **1-866-326-7248** 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?	$1,250 per plan participant $3,750 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. Urgent care, preventive care, office visits, office surgery, and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, however 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?	$2,500 per plan participant $7,500 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?	Premiums, balance-billing charges (unless balanced billing is prohibited), cost containment penalties, prescription drug discounts/coupons and DAW penalties, 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 1-866-326-7248 for a list of network providers.	This plan uses provider networks that include Direct Contract providers, and physician and other professional provider services. You will pay less if you use a provider in the plan's network. You will pay the most if you use a non-network provider, and you might receive a bill from that provider for the difference between their charge and what your plan pays (balance billing). Be aware, your network provider might use a non-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.



Common Medical Event	Services You May Need	What You Will Pay: Network Providers (You will pay the least)	What You Will Pay: Non-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	$50 <u>copayment</u> per visit, <u>deductible</u> does not apply	$50 <u>copayment</u> per visit, <u>deductible</u> does not apply	The office visit <u>copayment</u> applies to the visit charge and includes all services performed as part of the visit, for the same date of service. Charges incurred in the absence of a visit charge are payable per normal <u>plan</u> provisions.
	<u>Specialist</u> visit	$70 <u>copayment</u> per visit, <u>deductible</u> does not apply	$70 <u>copayment</u> per visit, <u>deductible</u> does not apply	
	<u>Preventive care/screening/</u> Immunization Facility Charge Physician Charge	Facility Charge: No charge Physician Charge: No charge	Physician Charge: No charge	You may have to pay for services that aren't <u>preventive</u>. Ask your <u>provider</u> if the services needed are <u>preventive</u>, then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work) Facility Charge Physician Charge	Facility Charge: 25% <u>coinsurance</u> Physician Charge: 15% <u>coinsurance</u>	Physician Charge: 25% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs) Facility Charge Physician Charge	Facility Charge: 25% <u>coinsurance</u> Physician Charge: 15% <u>coinsurance</u>	Physician Charge: 25% <u>coinsurance</u>	Imaging services may be available at no cost through *Green Imaging, LLC;* contact <u>www.greenimaging.net.</u> *Pre-certification of imaging services (<u>not performed by Green Imaging, LLC)</u>, is required to avoid a penalty.*
		Select Pharmacy	**Non-Select Pharmacy**	
If you need drugs to treat your illness or condition More information about **<u>prescription drug coverage</u>** is available at <u>https://veracity.procarerx.com</u>	Generic drugs (Tier 1)	$15 <u>copayment</u> per prescription (retail)	$35 <u>copayment</u> per prescription (retail)	Deductible does not apply to prescription drugs. Retail drugs are limited to a 30-day supply per prescription. A 90-day supply of Tier 1, 2, & 3 drugs may be available at 3x the retail copayment amount when utilizing a select pharmacy. <u>Specialty drugs</u> and mail order drugs are not covered. Infusion therapy drug charges that exceed $5,000 per visit, administered other than inpatient or outpatient, must be obtained through the Veracity Rx Prescription Drug Program; call (678) 529-6710.
	Preferred brand drugs (Tier 2)	$50 <u>copayment</u> per prescription (retail)	$70 <u>copayment</u> per prescription (retail)	
	Non-preferred brand drugs (Tier 3)	$100 <u>copayment</u> per prescription (retail)	$120 <u>copayment</u> per prescription (retail)	
	<u>Specialty drugs</u> (Tier 4)	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>		*Pre-certification of outpatient surgeries and procedures is required to avoid a penalty.*
	Physician/surgeon fees	15% <u>coinsurance</u>	25% <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 Providers (You will pay the least)	Non-Network Providers (You will pay the most)	
If you need immediate medical attention	Emergency room care Facility Charge	$250 copayment per visit; then 25% coinsurance		The Emergency room care copayment includes all services incurred during the visit and will be waived if admitted. *Pre-certification subsequent to an admission from the emergency room is required to avoid a penalty.*
	Physician Charge	25% coinsurance		
	Emergency medical transportation	25% coinsurance		None
	Urgent care Facility Charge	$70 copayment per visit; deductible does not apply		The urgent care copayment includes all services received during the urgent care visit. The Physician Charge copayment will not apply if a Facility Charge is also submitted.
	Physician Charge	$70 copayment per visit; deductible does not apply	$70 copayment per visit; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance		*Pre-certification of inpatient admissions is required to avoid penalty.*
	Physician/surgeon fees	15% coinsurance	25% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient/partial hospitalization Facility Charge	25% coinsurance		The office visit copayment applies to the visit charge and includes all services performed as part of the visit, for the same date of service. Charges incurred in the absence of a visit charge are payable per normal plan provisions.
	Physician Charge	15% coinsurance	25% coinsurance	
	Office visits Primary Care Physician	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply	
	Specialty Physician	$70 copayment per visit, deductible does not apply	$70 copayment per visit, deductible does not apply	
	Inpatient services Facility Charge	25% coinsurance		*Pre-certification of inpatient admissions is required to avoid a penalty.*
	Physician Charge	15% coinsurance	25% coinsurance	
If you are pregnant	Office visits	15% coinsurance	25% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). *Pre-certification of a maternity admission exceeding 48 hours for a vaginal delivery or 96 hours following a cesarean section delivery is required to avoid a penalty.*
	Childbirth/delivery professional services	15% coinsurance	25% coinsurance	
	Childbirth/delivery facility services	25% coinsurance		

* 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: Network Providers (You will pay the least)	What You Will Pay: Non-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information*
If you need help recovering or have other special health needs	Home health care Facility Charge Physician Charge	25% coinsurance 15% coinsurance	25% coinsurance 25% coinsurance	Coverage is limited to 90 visits per calendar year. *Pre-certification of home health care is required to avoid a penalty.*
	Rehabilitation services Inpatient Facility Charge Physician Charge Outpatient Facility Charge Physician Charge	25% coinsurance 15% coinsurance 25% coinsurance 15% coinsurance	25% coinsurance 25% coinsurance 25% coinsurance 25% coinsurance	*Pre-certification of inpatient admissions is required to avoid a penalty.*
	Habilitation services	See Rehabilitation services.	See Rehabilitation services.	
	Skilled nursing care	25% coinsurance	25% coinsurance	*Pre-certification of inpatient admissions is required to avoid a penalty.* Coverage is limited to 90 days per calendar year.
	Durable medical equipment	15% coinsurance	25% coinsurance	*Pre-certification of durable medical equipment over $2,000, and all Positive Airway Pressure (PAP) machines and humidifiers (regardless of the cost), is required to avoid a penalty.*
	Hospice services Facility Charge Physician Charge	25% coinsurance 15% coinsurance	25% coinsurance 25% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Vision benefits may be available through a separate plan election.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Dental benefits may be available through a separate plan election.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- 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
- Weight loss programs

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

- Chiropractic care

* 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 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 on how 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. Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and 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 the 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 1-866-326-7248.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-326-7248.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-326-7248.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'1-866-326-7248.

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)

■ **The plan's overall deductible**	**$1,250**
■ **Primary care copayment**	**$50**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**15%**

This EXAMPLE event includes services like:

Primary care 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	$1,250
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,510**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well- controlled condition)

■ **The plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$70**
■ **Hospital (facility) coinsurance**	**25%**
■ **Other coinsurance**	**15%**

This EXAMPLE event includes services like:

Specialty physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Medical supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$1,250**
■ **Specialist copayment**	**$70**
■ **Hospital (ER facility) copay/coins**	**$250/25%**
■ **Other coinsurance**	**15%**

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	$1,250
Copayments	$460
Coinsurance	$170
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,880**

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