




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 1-866-326-7018. 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> ?	Preferred Providers: \$3,000 per plan participant/ \$6,000 per family unit Non-Preferred Providers: \$6,000 per plan participant/ \$12,000 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there <u>services</u> covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , <u>urgent care</u> and office visits are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and <u>services</u> 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 <u>services</u> ?	No.	You don't have to meet <u>deductibles</u> for specific <u>services</u> .
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Preferred Providers: \$3,000 per plan participant/ \$6,000 per family unit Non-Preferred Providers: \$6,200 per plan participant/ \$12,400 per family unit	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered <u>services</u> . If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , penalties for failure to pre-certify, <u>balance-billing</u> charges (unless <u>balance billing</u> is prohibited), 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 1-866-326-7018 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 plan's <u>network</u> . You will pay the most if you use an <u>non-preferred 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>preferred provider</u> might use an <u>non-preferred provider</u> for some <u>services</u> (such as lab work). Check with your <u>provider</u> before you get <u>services</u> .
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*
		Preferred Provider (You will pay the least)	Non-Preferred 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% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Specialist</u> visit	0% <u>coinsurance</u>	10% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for <u>services</u> that aren't <u>preventive</u> . Ask your <u>provider</u> if the <u>services</u> needed are <u>preventive</u> . Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Pre-certification required prior to imaging services to avoid a penalty.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ProCareRx.com	Generic drugs (Tier 1)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Deductible does apply to <u>prescription drug coverage</u> .
	Preferred brand drugs (Tier 2)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Non-preferred brand drugs (Tier 3)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Coverage available up to a 90-day supply (retail pharmacy only) at 3 times the 30-day supply <u>copayment</u> . Mail Order is not available.
	<u>Specialty drugs</u> (Tier 4)	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Pre-certification required prior to outpatient <u>services</u> to avoid a penalty.
	Physician/surgeon fees	0% <u>coinsurance</u>	10% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>		None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>		None
	<u>Urgent care</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Pre-certification required prior to inpatient admissions to avoid a penalty.
	Physician/surgeon fees	0% <u>coinsurance</u>	10% <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*
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient <u>services</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Pre-certification required prior to inpatient admissions and outpatient <u>services</u> to avoid a penalty.
	Office visits	0% <u>coinsurance</u>	10% <u>coinsurance</u>	
	Inpatient <u>services</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	
If you are pregnant	Office visits	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Maternity benefits only apply to covered employee or covered spouse. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of <u>services</u> , <u>coinsurance</u> may apply. Maternity care may include tests and <u>services</u> described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional <u>services</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	
	Childbirth/delivery facility <u>services</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Pre-certification required prior to <u>home health care</u> to avoid a penalty. Coverage is limited to 60 visits/calendar year.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Outpatient rehabilitation includes physical therapy, speech therapy, and occupational therapy and is limited to combined 60 visits /calendar year. Cardiac and Pulmonary rehabilitation limited to 36 visits per occurrence. Pre-certification required prior to inpatient admissions and outpatient <u>services</u> to avoid a penalty.
	<u>Habilitation services</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Pre-certification required prior to <u>skilled nursing care</u> to avoid a penalty. Coverage is limited to 60 days/calendar year.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Pre-certification required prior to <u>durable medical equipment</u> to avoid a penalty.
	<u>Hospice services</u>	0% <u>coinsurance</u>	10% <u>coinsurance</u>	Coverage is limited to 60 visits/calendar year.
If your child needs dental or eye care	Children's eye exam	Not covered		Not covered
	Children's glasses	Not covered		Not covered
	Children's dental check-up	Not covered		Not covered

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

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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs
- Routine eye care (Adult)

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing

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: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.HealthCare.gov). For more information about the [Marketplace](http://www.HealthCare.gov), 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: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 1-866-326-7018.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-326-7018.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-326-7018.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-326-7018.

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** **\$3,000**
- **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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,940
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,000

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **\$3,000**
- **Specialist 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$520
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,580

Mia's Simple Fracture

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

- **The plan's overall deductible** **\$3,000**
- **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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800