




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 1-866-312-6723 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?	\$1,500 per covered person; \$3,000 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 drug coverage</u> , <u>home health care</u> , <u>hospice services</u> and the following preferred provider services: physician office visits, preventive care, spinal manipulation / chiropractic care and WellVia Telehealth 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 Benefits: \$3,000 per covered person; \$6,000 per family unit Prescription drug coverage: \$1,450 per covered person; \$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 coverage out-of-pocket limits</u> , <u>premiums</u> , <u>balance-billing</u> charges (unless <u>balanced billing</u> is prohibited), amounts over the allowable charge, 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.ebms.com or call 1-866-312-6723 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> .
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 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	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	The office visit <u>copayment</u> includes laboratory and x-ray services rendered and billed during the office visit only.
	<u>Specialist</u> visit	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	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 for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work) Facility Independent lab Physician services	30% <u>coinsurance</u>		Charges for 3-D mammography will be covered.
		30% <u>coinsurance</u>	40% <u>coinsurance</u>	
		30% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Imaging (CT/PET scans, MRIs) Facility Physician services	30% <u>coinsurance</u>		None
30% <u>coinsurance</u>		40% <u>coinsurance</u>		
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.ebms.com or call ProAct toll-free at 1-877-635-9545.	Tier 1 (All other covered generics and some lower cost brand products)	\$15 <u>copayment</u> / 30-day prescription (retail); \$30 <u>copayment</u> / prescription (mail order)	50% <u>coinsurance</u> / <u>prescription(retail)</u>	The medical <u>deductible</u> does not apply to <u>prescription drug coverage</u> .
	Tier 2 (Preferred brand products)	\$40 <u>copayment</u> / 30-day prescription (retail); \$80 <u>copayment</u> / prescription (mail order)	50% <u>coinsurance</u> / <u>prescription(retail)</u>	All <u>prescription drug coverage</u> is subject to a separate out-of-pocket limit. Coverage is available up to a 90-day supply (retail pharmacy) and a 31 to 90-day supply (mail order pharmacy).
	Tier 3 (Non-preferred brand products)	50% <u>coinsurance</u> / (retail or mail order)	50% <u>coinsurance</u> / <u>prescription(retail)</u>	

* 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)	
	<u>Specialty drugs</u>	\$100 <u>copayment</u> / 30-day prescription	Not covered	<u>Specialty drugs</u> are mandatory through the specialty pharmacy (after the first fill through the retail pharmacy) and limited to a 30-day supply. For more information regarding the Specialty Pharmacy Program, please contact Noble Health Services toll-free at 1 (888) 843-2040 or visit www.noblehealthservices.com .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>		None
	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>		None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>		None
	<u>Urgent care Facility</u>	30% <u>coinsurance</u>		The <u>Urgent Care</u> office visit <u>copayment</u> applies only to the <u>urgent care</u> office visit. All other services rendered during the urgent care office visit will be payable per normal <u>plan</u> provisions.
	<u>Office visit</u>	\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>		None
	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services Facility Physician Office visits:	30% <u>coinsurance</u>		None
		30% <u>coinsurance</u>	40% <u>coinsurance</u>	
		\$35 <u>copayment</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	Inpatient services Facility Physician	30% <u>coinsurance</u>		None
		30% <u>coinsurance</u>	40% <u>coinsurance</u>	

* 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 are pregnant	Office visits	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<p><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).</p>	
	Childbirth/delivery professional services	30% <u>coinsurance</u>	40% <u>coinsurance</u>		
	Childbirth/delivery facility services	30% <u>coinsurance</u>			
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u> <u>deductible</u> does not apply		Coverage is limited to 180 visits per calendar year.	
	<u>Rehabilitation services Facility</u>	30% <u>coinsurance</u>		<p>Outpatient rehabilitation includes cardiac, physical, speech, and occupational therapies and is limited to 20 combined visits per calendar year. And additional 10 combined outpatient visits in increments of 5 will be allowed with prior certification. An additional 3-to-1 swap of skilled nursing facility for pre-certified treatment plan. Applied Behavioral Analysis will be limited to 152 visits per calendar year from birth through age 18 years. Down syndrome therapies (for covered dependent children from birth through age 17 years) is limited to 52 visits per calendar year per therapy for occupational and physical therapy and 104 visits per calendar year for speech therapy.</p>	
	<u>Physician</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>		
	<u>Habilitation services Facility</u>	30% <u>coinsurance</u>			
	<u>Physician</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>		
	<u>Skilled nursing care Facility</u>	30% <u>coinsurance</u>			Limited to 60 days per calendar year.
	<u>Physician</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>		
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>		None
	<u>Hospice services Facility</u>	No charge			None
	<u>Physician</u>	No charge	No charge		
If your child needs dental or eye care	Children's eye exam	No charge			Limited to 1 exam per calendar year.
	Children's glasses	Not covered		Coverage is available through a separate enrollment.	
	Children's dental check-up	Not covered		No coverage for dental care.	

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

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 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
- Routine eye care (Adult)

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. 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: 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 1-866-312-6723.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-312-6723.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-312-6723.

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-866-312-6723.

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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 \$1,500
- Specialist copayment \$35
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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:

Cost Sharing

<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$3,060
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Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1,500
- Specialist copayment \$35
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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:

Cost Sharing

<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,500
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$1,620
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Mia's Simple Fracture

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

- The plan's overall deductible \$1,500
- Specialist copayment \$35
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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:

Cost Sharing

<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$300

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$1,900
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