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 **1-866-439-7700** 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?	$300 per covered person.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, morbid obesity surgery, prescription drugs, and *Participating Provider Facility charges for:* inpatient or outpatient care and diagnostic testing 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?	MEDICAL: *Participating Provider Facilities & Professional Services*: $2,300 per covered person; $6,900 per family unit. *Non-Participating Facilities:* $4,300 per covered person; $12,900 per family unit. PRESCRIPTION DRUGS: $4,000 per covered person; $6,000 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 drugs, 3-month deductible carryover, premiums, balance-billing charges (unless balanced billing is prohibited), 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 1-866-439-7700 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*
		Participating Provider (You will pay the least)	Non-Participating 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	20% coinsurance		None
	Specialist visit	20% coinsurance		
	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) Facility	20% coinsurance, deductible does not apply	40% coinsurance	None
	Physician	20% coinsurance		
	Imaging (CT/PET scans, MRIs) Facility	20% coinsurance, deductible does not apply	40% coinsurance	Outpatient imaging services (such as MRI, CT, or PET scan) require pre-authorization to avoid a 50% benefit reduction or denial.
	Physician	20% coinsurance		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	10% coinsurance up to $75 per prescription (retail or mail order)		Prescription drugs are not subject to the medical deductible. Retail drugs are limited to a 34-day supply per prescription; at select Participating Pharmacies, a 90-day supply per prescription may be available at the mail order copayment amount. Mail order drugs are available up to a 90-day supply per prescription. Specialty drugs are limited to a 30-day supply per prescription.
	Formulary brand drugs	20% coinsurance up to $150 per prescription (retail or mail order)		
	Non-Formulary brand drugs	30% coinsurance up to $300 per prescription (retail or mail order)		
	Specialty drugs	15% coinsurance up to $150 per prescription (retail only) Prior authorization is required for all specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance, deductible does not apply	40% coinsurance	Failure to comply with the mandatory engagement of BridgeHealth for surgery will incur a $200 penalty.
	Physician/surgeon fees	20% coinsurance		
If you need immediate medical attention	Emergency room care	20% coinsurance		Non-emergency visits to an emergency room will incur a $200 penalty.
	Emergency medical transportation	20% coinsurance		None
	Urgent care Facility	20% coinsurance, deductible does not apply	40% coinsurance	None
	Physician	20% 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		Limitations, Exceptions, & Other Important Information*
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance, deductible does not apply	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance		Coverage is limited to 40 visits per calendar year.
	Inpatient services Facility	20% coinsurance, deductible does not apply	40% coinsurance	Coverage is limited to 20 days per calendar year with a lifetime limit of 50 days.
	Physician	20% coinsurance		
If you are pregnant	Office visits	20% coinsurance		Coverage is limited to the Employee or Spouse only. 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).
	Childbirth/delivery professional services	20% coinsurance		
	Childbirth/delivery facility services	20% coinsurance, deductible does not apply	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance		Coverage is limited to 120 visits per calendar year.
	Rehabilitation services Inpatient/Outpatient	20% coinsurance		Coverage of outpatient physical therapy and chiropractic care have a (combined) limit of 25 visits per calendar year.
	Habilitation services Inpatient/Outpatient	20% coinsurance		
	Skilled nursing care	20% coinsurance		Coverage is limited to 150% of the daily hospital charge.
	Durable medical equipment	20% coinsurance		None
	Hospice services	20% coinsurance		None
If your child needs dental or eye care	Children's eye exam	Not covered		Vision and Dental benefits may be available through a separate benefit election.
	Children's glasses	Not covered		
	Children's dental check-up	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	• Infertility treatment	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult)	• Private-duty nursing (outpatient)	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Hearing aids *($400 every 36 months)*	• Non-emergency care when traveling outside the U.S.
• Chiropractic care		

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 **1-866-439-7700**

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-439-7700**

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码 1-866-439-7700**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-439-7700**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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**	**$300**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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	$300
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,360**

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

■ **The plan's overall deductible**	**$300**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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	$300
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

■ **The plan's overall deductible**	**$300**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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	$300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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