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 1-866-326-7072 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?	$4,500 per plan participant, $9,000 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. Preventive care is 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?	$7,500 per plan participant, $15,000 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?	Premiums, prescription drug DAW penalties & discounts/coupons, 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?	See https://partnersdirecthealth.com/ or call 888-642-2732 for a list of network providers.	You may see any provider for facility or physician services, however this plan uses a provider network for Physician based charges. You will pay less if you use a physician in the plan's network. You will pay the most if you use a non-network physician, and you might receive a bill from a provider for the difference between their charge and what your plan pays (balance billing). Be aware, your network physician might use a non-network physician 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*
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment per visit	The copayment applies once per visit and includes lab & x-ray associated with the visit for the same date of service, billed by the same or different provider.
	Specialist visit	$60 copayment per visit	
	Preventive care/screening/Immunizations	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.
If you have a test	Diagnostic test (x-ray, blood work) Inpatient/Outpatient Facility	10% coinsurance	The urgent care diagnostic test copayment will only apply once per visit and may be combined with other services performed during the visit. Diagnostic testing associated with and incurred on the same date as an office visit are included under the office visit copayment.
	Physician	10% coinsurance	
	Freestanding surgery/radiology Facility	10% coinsurance	
	Physician	10% coinsurance	
	Emergency room services	10% coinsurance	
	Urgent care services	$60 copayment per visit	
	Office	10% coinsurance	
	Imaging (CT/PET scans, MRIs) Inpatient/Outpatient Facility	10% coinsurance	The urgent care imaging copayment applies once per visit; and may be combined with other services performed during the visit.
	Physician	10% coinsurance	
	Freestanding surgery/radiology Facility	10% coinsurance	
	Physician	10% coinsurance	
	Emergency room services	10% coinsurance	
	Urgent care services	$60 copayment per visit	
	Office	10% 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*
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at https://veracity.procarerx.com	Generic drugs	*Select Retail pharmacy:* $5 copayment per prescription (34-day supply) $15 copayment per prescription (90-day supply) *Non-Select Retail pharmacy:* $15 copayment per prescription (34-day supply)	Deductible applies to prescription drugs. Retail drugs are limited to a 34-day supply per prescription; a 90-day supply may be available when utilizing a Select retail pharmacy. Mail order pharmacy and specialty drugs are not covered. The following pharmacies are considered a *non-Select pharmacy* under this plan: CVS, Rite Aid, Target, and Walgreens.
	Formulary brand drugs	*Select Retail pharmacy:* $40 copayment per prescription (34-day supply) $100 copayment per prescription (90-day supply) *Non-Select Retail pharmacy:* $40 copayment per prescription (34-day supply)	
	Non-formulary brand drugs	*Select Retail pharmacy:* $80 copayment per prescription (34-day supply) $200 copayment per prescription (90-day supply) *Non-Select Retail pharmacy:* $80 copayment per prescription (34-day supply)	
	Specialty drugs	Not covered	
If you have outpatient surgery	Facility fee *Freestanding* surgery facility Outpatient facility	 10% coinsurance 10% coinsurance	None
	Physician/surgeon fees Freestanding surgery facility Outpatient facility	 10% coinsurance 10% coinsurance	None
If you need immediate medical attention	Emergency room care Facility Physician Other facility charges	 10% coinsurance 10% coinsurance 10% coinsurance	None
	Emergency medical transportation	10% coinsurance	None
	Urgent care Office visit Outpatient facility	 $60 copayment per visit 10% coinsurance	The copayment applies once per visit and may be combined with other services performed during the visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	None
	Physician/surgeon fees	10% coinsurance	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*
If you need mental health, behavioral health, or substance abuse services	Outpatient services Facility	10% coinsurance	The copayment applies once per visit and includes lab & x-ray associated with the visit for the same date of service, billed by the same or different provider.
	Physician	10% coinsurance	
	Office	0% coinsurance	
	Inpatient services Facility	10% coinsurance	None
	Physician	10% coinsurance	
If you are pregnant	Office visits Primary care physician	$30 copayment per visit	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance and/or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Specialist physician	$60 copayment per visit	
	Childbirth/delivery professional services	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	
If you need help recovering or have other special health needs	Home health care Facility	10% coinsurance	Coverage is limited to 120 visits per calendar year. The visit limit does not apply to home infusion therapy or home dialysis/hemodialysis.
	Physician	10% coinsurance	
	Rehabilitation services Inpatient Facility	10% coinsurance	Inpatient services are limited to 60 days per calendar year (combined with Skilled Nursing). Outpatient/office therapy calendar year visit limits: physical & occupational therapy/20 visits (combined); speech therapy/20 visits, chiropractic/manipulation therapy/20 visits. *Therapy visit limits do not apply to treatment of autism spectrum disorders.*
	Inpatient Physician	10% coinsurance	
	Outpatient therapies-Facility	10% coinsurance	
	Outpatient therapies-Physician	10% coinsurance	
	Office therapies	10% coinsurance	
	Habilitation services	See Rehabilitation services	
	Skilled nursing care	10% coinsurance	Skilled nursing care is limited to 60 days per calendar year (combined with Rehabilitation services).
	Durable medical equipment (DME) DME provider	10% coinsurance	Durable medical equipment benefits are based on the setting in which the service is provided. The urgent care DME copayment and/or office visit DME copayment will only apply once per visit and may be combined with other services performed during the visit.
	Inpatient/Outpatient facility	10% coinsurance	
	Freestanding facility	10% coinsurance	
	Emergency room services	10% coinsurance	
	Urgent care services	$60 copayment per visit	
	Office-Primary care physician	$30 copayment per visit	
	Office-Specialist physician	$60 copayment per visit	
	Hospice services Facility	0% coinsurance	Physical, occupational, & speech therapy visit limits do not apply to therapy incurred under hospice care.
	Physician	0% coinsurance	
If your child	Children's eye exam	Not covered	Vision benefits may be available through a separate plan

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information*
needs dental or eye care	Children's glasses	Not covered	election.
	Children's dental check-up	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/Child)	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult/Child) • 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	• Hearing aids (age 18 & under only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information, contact Americomp Benefits, Inc. at 706-327-6511, or 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 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: 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 can help you file 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-866-326-7072.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-326-7072.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-866-326-7072.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-326-7072.

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** **$4,500**
- **Primary care physician copayment** **$30**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician 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	$4,500
Copayments	$10
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,370**

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

- **The plan's overall deductible** **$4,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$4,500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,020**

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

- **The plan's overall deductible** **$4,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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