
 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?	\$1,800 per plan participant, \$5,400 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. Inpatient facility, Freestanding surgical facilities, freestanding radiology centers; emergency room services; urgent care services; office visits; preventive care, 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?	\$4,500 per plan participant, \$9,000 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?	Yes. See www.ebms.com or call (866) 326-7072 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 a non-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 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.

 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	\$35 <u>copayment</u> per visit; <u>deductible</u> does not apply	The <u>copayment</u> 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.
	<u>Specialist</u> visit	\$70 <u>copayment</u> per visit; <u>deductible</u> does not apply	
	Preventive care/screening/immunization Facility Physician	No 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	Diagnostic test (x-ray, blood work) Inpatient/Outpatient		The <u>urgent care diagnostic testing copayment</u> 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 <u>copayment</u> .
	Facility Physician	20% <u>coinsurance</u> 20% <u>coinsurance</u>	
	Freestanding surgery/radiology Facility Physician	20% <u>coinsurance</u> ; <u>deductible</u> does not apply 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	<u>Emergency room services</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	<u>Urgent care services</u> Office	\$75 <u>copayment</u> per visit; <u>deductible</u> does not apply 20% <u>coinsurance</u>	
	Imaging (CT/PET scans, MRIs) Inpatient/Outpatient		
	Facility Physician	20% <u>coinsurance</u> 20% <u>coinsurance</u>	The <u>urgent care imaging copayment</u> applies once per visit and may be combined with other services performed during the visit.
	Freestanding surgery/radiology Facility Physician	20% <u>coinsurance</u> ; <u>deductible</u> does not apply 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	<u>Emergency room services</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	<u>Urgent care services</u> Office	\$75 <u>copayment</u> per visit; <u>deductible</u> does not apply 20% <u>coinsurance</u>	
	Imaging (CT/PET scans, MRIs) Inpatient/Outpatient		
	Facility Physician	20% <u>coinsurance</u> 20% <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*
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at https://veracity.procarerx.com	Generic drugs	<i>Select Retail pharmacy:</i> \$5 <u>copayment</u> per prescription (34-day supply) \$15 <u>copayment</u> per prescription (90-day supply) <i>Non-Select Retail pharmacy:</i> \$15 <u>copayment</u> per prescription (34-day supply)	Retail drugs are limited to a 34-day supply per prescription; a 90-day supply may be available when utilizing a Select retail pharmacy.
	Formulary brand drugs	<i>Select Retail pharmacy:</i> \$60 <u>copayment</u> per prescription (34-day supply) \$90 <u>copayment</u> per prescription (90-day supply) <i>Non-Select Retail pharmacy:</i> Not covered	Mail order pharmacy and <u>specialty drugs</u> are not covered.
	Non-formulary brand drugs	Not covered	The following pharmacies are considered a <i>non-Select pharmacy</i> under this <u>plan</u> : CVS, Rite Aid, Target, and Walgreens.
	<u>Specialty drugs</u>	Not covered	
If you have outpatient surgery	Facility fee <i>Freestanding surgery facility</i>	\$150 <u>copayment</u> per visit, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	Outpatient facility	20% <u>coinsurance</u>	
	Physician/surgeon fees <i>Freestanding surgery facility</i>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	Outpatient facility	20% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u> Facility	\$350 <u>copayment</u> per visit, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	The <u>copayment</u> is waived if admitted.
	Physician	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	Other facility charges	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u> Office visit Outpatient facility	\$75 <u>copayment</u> per visit; <u>deductible</u> does not apply 20% <u>coinsurance</u>	The <u>copayment</u> applies once per visit (except allergy serum).
If you have a hospital stay	Facility fee (e.g., hospital room) Room & Board	\$500 <u>copayment</u> per admission, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	Other facility services	20% <u>coinsurance</u>	
	Physician/surgeon fees	20% <u>coinsurance</u>	None

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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		The office <u>copayment</u> 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.
	Facility	20% <u>coinsurance</u>	
	Physician	20% <u>coinsurance</u>	
	Office	\$35 <u>copayment</u> per visit; <u>deductible</u> does not apply	
	Inpatient services		None
	Facility	\$500 <u>copayment</u> per admission, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	Physician	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
If you are pregnant	Office visits		Cost sharing does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> and/or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Primary care physician	\$35 <u>copayment</u> per visit; <u>deductible</u> does not apply	
	Specialist physician	\$70 <u>copayment</u> per visit; <u>deductible</u> does not apply	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 <u>copayment</u> per admission, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
If you need help recovering or have other special health needs	<u>Home health care</u>		Coverage is limited to 100 visits per calendar year. The visit limit does not apply to home infusion therapy or home dialysis/hemodialysis.
	Facility	20% <u>coinsurance</u>	
	Physician	20% <u>coinsurance</u>	
	<u>Rehabilitation services</u>		Inpatient services are limited to 60 days per calendar year (combined with <u>Skilled Nursing</u>). Outpatient/office therapy calendar year visit limits: physical & occupational therapy/20 visits (combined); speech therapy/20 visits, chiropractic/manipulation therapy/20 visits. <i>Therapy visit limits do not apply to treatment of autism spectrum disorders.</i>
	Inpatient facility	\$500 <u>copayment</u> per admission, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	Inpatient Physician	20% <u>coinsurance</u>	
	Outpatient therapies		
	Facility	20% <u>coinsurance</u>	
	Physician	20% <u>coinsurance</u>	
	Office therapies		
Cardiac rehab/pulmonary & respiratory therapies	20% <u>coinsurance</u>		
Physical/speech/occupational/chiro/manipulation therapies	\$70 <u>copayment</u> per visit; <u>deductible</u> does not apply		
<u>Habilitation services</u>	See <u>Rehabilitation services</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*
If you need help recovering or have other special health needs	Skilled nursing care	\$500 <u>copayment</u> per admission, then 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Skilled nursing care</u> is limited to 60 days per calendar year (combined with <u>Rehabilitation services</u>).
	Durable medical equipment (DME)		<u>Durable medical equipment</u> benefits are based on the setting in which the service is provided. The <u>urgent care</u> DME <u>copayment</u> and/or office visit DME <u>copayment</u> will only apply once per visit and may be combined with other services performed during the visit.
	DME provider	20% <u>coinsurance</u>	
	Inpatient/Outpatient facility	20% <u>coinsurance</u>	
	Freestanding facility	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	<u>Emergency room services</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	<u>Urgent care services</u>	\$75 <u>copayment</u> per visit; <u>deductible</u> does not apply	
	Office-Primary care physician	\$35 <u>copayment</u> per visit; <u>deductible</u> does not apply	
Office-Specialist physician	\$70 <u>copayment</u> per visit; <u>deductible</u> does not apply		
Hospice services	Facility	20% <u>coinsurance</u>	Physical, occupational, & speech therapy visit limits do not apply to therapy incurred under hospice care.
	Physician	20% <u>coinsurance</u>	
If your child needs dental or eye care	Children's eye exam	Not covered	Vision benefits may be available through a separate <u>plan</u> election.
	Children's glasses	Not covered	
	Children's dental check-up	Not covered	Dental benefits may be available through a separate <u>plan</u> election.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult/Child) 	<ul style="list-style-type: none"> Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing 	<ul style="list-style-type: none"> 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> Chiropractic care 	<ul style="list-style-type: none"> Hearing aids (age 18 & under only) 	

* 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. 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

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 1-866-326-7072.

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, kwijigo 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 \$1,800
- Primary care physician \$35
- Hospital (facility) copayment \$500
- Other coinsurance 20%

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,800
<u>Copayments</u>	\$510
<u>Coinsurance</u>	\$1,750
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,120

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1,800
- Specialist copayment \$70
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions*	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

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

- The plan's overall deductible \$1,800
- Specialist copayment \$70
- Hospital (ER facility) copayment \$350
- 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,200
<u>Copayments</u>	\$850
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,140