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?	$2,800 per covered person; $5,600 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 services and certain Health Savings Account (HSA) preventive prescription drug medications and WellVia Telehealth are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But 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 Benefits:** $2,800 per covered person; $5,600 per family unit **Prescription drug coverage:** $1,450 per covered person; $2,900 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 drug coverage out-of-pocket limits, premiums, balance-billing charges (unless balanced billing is prohibited), pre-certification penalties, amounts over the allowable charge, 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 1-866-312-6723 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
		Preferred Providers (you will pay the least)	Non-Preferred Providers (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% coinsurance		None
	Specialist visit	0% coinsurance		
	Preventive care/screening/ immunization	No charge	0% coinsurance	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)	0% coinsurance		None
	Imaging (CT/PET scans, MRIs)	0% coinsurance		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** 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 copayment/ prescription (retail); $30 copayment/ prescription (mail order)	50% coinsurance / prescription (retail pharmacy)	The medical deductible will apply to all prescription drug coverage, except for certain Health Savings Account (HSA) preventive medications will be available through the retail pharmacy or the mail order pharmacy subject of the waiver of the medical deductible. Contact ProAct for more information and a list of these preventive medications. All prescription drug coverage is subject to a separate out-of-pocket limit. Coverage limited to a 30-day supply (retail pharmacy) and a 31 to 90-day supply (mail order pharmacy).
	Tier 2 (Preferred brand products)	$40 copayment/ prescription (retail); $80 copayment/ prescription (mail order)	50% coinsurance / prescription (retail pharmacy)	
	Tier 3 (Non-preferred brand products)	50% coinsurance/ prescription (retail or mail order)	50% coinsurance / prescription (retail pharmacy)	
	Specialty drugs	$100 copayment/ prescription	Not covered	Specialty drugs are mandatory through the specialty pharmacy (after the first fill through the retail pharmacy). Specialty drugs are limited to a 30-day supply. Contact ProAct for more information regarding specialty drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Providers (you will pay the least)	Non-Preferred Providers (you will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance		None
	Physician/surgeon fees	0% coinsurance		None
If you need immediate medical attention	Emergency room care	0% coinsurance		None
	Emergency medical transportation	0% coinsurance		None
	Urgent care	0% coinsurance		None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance		Failure to pre-certify care, treatment or a service may result in the Plan's benefit level being reduced to 50%. Penalties for failure to pre-certify do not accrue to the out-of-pocket maximum amount.
	Physician/surgeon fees	0% coinsurance		None
If you need mental health, behavioral health, or substance abuse services	Outpatient services Office visits	0% coinsurance 0% coinsurance		None
	Inpatient services	0% coinsurance		Failure to pre-certify care, treatment or a service may result in the Plan's benefit level being reduced to 50%. Penalties for failure to pre-certify do not accrue to the out-of-pocket maximum amount.
If you are pregnant	Office visits	0% coinsurance		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	0% coinsurance		
	Childbirth/delivery facility services	0% coinsurance		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Providers (you will pay the least)	Non-Preferred Providers (you will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance		Failure to pre-certify care, treatment or a service may result in the Plan's benefit level being reduced to 50%. Penalties for failure to pre-certify do not accrue to the out-of-pocket maximum amount. Coverage is limited to 180 visits per calendar year.
	Rehabilitation services	0% coinsurance		Outpatient rehabilitation includes cardiac, physical, speech, and occupational therapies and is limited to 20 combined visits per calendar year. An additional 10 combined outpatient visits in increments of 5 will be allowed with prior authorization. An additional 3-to-1 swap of skilled nursing facility for pre-approved treatment plan. Failure to pre-certify care, treatment or a service may result in the Plan's benefit level being reduced to 50%. Penalties for failure to pre-certify do not accrue to the out-of-pocket maximum amount. Applied Behavioral Analysis will be limited to 152 visits per calendar year for ages birth through age 18 years. Down syndrome therapies (for covered dependent children from birth through age 17 years) will be limited to 52 visits per calendar year per therapy for occupational and physical therapy and 104 visits per calendar year for speech therapy.
	Habilitation services	0% coinsurance		
	Skilled nursing care	0% coinsurance		Limited to 60 days per calendar year. Failure to pre-certify care, treatment or a service may result in the Plan's benefit level being reduced to 50%. Penalties for failure to pre-certify do not accrue to the out-of-pocket maximum amount.
	Durable medical equipment	0% coinsurance		Pre-notification of durable medical equipment over $2,000 is strongly recommended.
	Hospice services	0% coinsurance		Pre-notification of hospice services is strongly recommended.

If your child needs dental or eye care	Children's eye exam	Not covered	No coverage for routine eye exams.
	Children's glasses	Not covered	No coverage for glasses or contact lenses.
	Children's dental check-up	Not covered	No coverage for dental care.

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)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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

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 **EBMS at 1-866-312-6723** or these agencies: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/ or 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 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 1-866-312-6723 or the DOL's Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. Contact your state's program if available at: 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 1-866-312-6723.
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 at'ohwol ninisingo, kwiijigo holne' 1-866-312-6723.

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

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**	**$2,800**
■ **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

■ **The plan's overall deductible**	**$2,800**
■ **Primary care physician 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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,860**

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

■ **The plan's overall deductible**	**$2,800**
■ **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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