This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ebms.com or by calling **1-866-312-6723**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**NRHA facilities: $1,000** person, **$2,000** family; **Non-NRHA facilities, Physicians and non-facility charges: $1,250** person**, $2,500** family; **Out-of-Network facilities: $1,500** person, **$3,000** family. Does not apply to coinsurance, co-payments, office visits, urgent care, home health care, hospice care or preventive care. Copayments do not apply to deductibles.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**NRHA facilities: $2,250** person, **$4,500** family; **Non-NRHA facilities, Physicians and non-facility charges: $2,500** person**, $5,000** family; **Out-of-Network facilities: $3,375** person, **$6,750** family. **Prescription Drug Benefits out-of-pocket limit: $1,450** person, **$2,900** family.	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Separate prescription drug out-of-pocket limits, premiums, balance-billed charges, cost containment penalties, (unless balanced billing is prohibited), 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See www.ebms.com for a list of preferred providers or call 1 (866) 312-6723	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-payment/ visit, deductible waived	40% co-insurance after deductible	The office visit copayment includes laboratory and x-ray services rendered and billed during the office visit only.
	Specialist visit	$35 co-payment/ visit, deductible waived	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Other practitioner office visit	$35 co-payment/visit, deductible waived	40% co-insurance after deductible	Limited to 15 visits per Calendar Year maximum; limited to one (1) set of chiropractic x-rays per Calendar Year.
	Preventive care/screening/immunization	No charge	40% co-insurance after deductible	————————none————————
If you have a test	Diagnostic test (x-ray, blood work) Facility	30% co-insurance after deductible		————————none————————
	Independent Laboratory or Physician services	30% co-insurance after deductible	40% co-insurance after deductible	
	Imaging (CT/PET scans, MRIs) Facility	30% co-insurance after deductible		————————none————————
	Physician services	30% co-insurance after deductible	40% co-insurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Tier 1 (All other covered generics and some lower cost brand products)	$15 co-payment/ prescription (retail pharmacy); $30 co-payment/ prescription (mail order pharmacy)	50%/ prescription (retail pharmacy only)	Limited to a 30-day supply through retail pharmacy and 90-day supply through mail order. Tier 1, Tier 2 and Tier 3 drugs, for both retail pharmacy and mail order, and Specialty Pharmacy medications will be subject to a Prescription Drug

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
www.ebms.comor by calling toll free 1 (866) 333-2757. .	Tier 2 (Preferred brand products)	$40 co-payment/ prescription (retail pharmacy); $80 co-payment/ prescription (mail order pharmacy)	50%/ prescription (retail pharmacy only)	out-of-pocket limit of $1,450 single coverage or $2,900 family coverage, per calendar year.
	Tier 3 (Non-preferred brand products)	50%/prescription (retail pharmacy and mail order pharmacy)	50%/prescription (retail pharmacy only)	
	Specialty Pharmacy	$100 co-payment /prescription (specialty pharmacy only)	Not Covered	Specialty medications are mandatory through the Specialty pharmacy after the first fill through the retail pharmacy. Specialty medications are available through the Specialty Pharmacy only. Contact Navitus Health Solutions toll-free at 1 (866) 333-2757 for more information regarding Specialty medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance after deductible		————————none————————
	Physician/surgeon fees	30% co-insurance after deductible	40% co-insurance after deductible	————————none————————
If you need immediate medical attention	Emergency room services Facility and Physician Charges	30% co-insurance after deductible		The Emergency Room facility charges will be payable subject to the NRHA facility deductible.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Emergency medical transportation	30% co-insurance after deductible		————————none————————
	Urgent care Facility	30% co-insurance after deductible		————————none————————
	Physician and Office Visit	$35 co-payment/visit, deductible waived	40% co-insurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance after deductible		Limited to the facility's semi-private room rate.
	Physician/surgeon fee	30% co-insurance after deductible	40% co-insurance after deductible	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Facility	30% co-insurance after deductible		Mental/Behavioral health facility charges will be payable subject to the NRHA facility deductible.
	Physician	30% co-insurance after deductible	40% co-insurance after deductible	
	Office Visit	$35 co-payment/visit, deductible waived	40% co-insurance after deductible	
	Mental/Behavioral health inpatient services Facility	30% co-insurance after deductible		Mental/Behavioral health facility charges will be payable subject to the NRHA facility deductible.
	Physician	30% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Substance use disorder outpatient services Facility	30% co-insurance after deductible		Substance use disorder facility charges will be payable subject to the NRHA facility deductible.
	Physician	30% co-insurance after deductible	40% co-insurance after deductible	
	Office Visit	$35 co-payment/visit, deductible waived	40% co-insurance after deductible	
	Substance use disorder inpatient services Facility	30% co-insurance after deductible		Substance use disorder facility charges will be payable subject to the NRHA facility deductible.
	Physician	30% co-insurance after deductible	40% co-insurance after deductible	
If you are pregnant	Prenatal and postnatal care	30% co-insurance after deductible	40% co-insurance after deductible	————————none————————
	Delivery and all inpatient services	30% co-insurance after deductible		Limited to the facility's semi-private room rate.
If you need help recovering or have other special health needs	Home health care	30% co-insurance / deductible waived		Limited to 180 visits per Calendar Year maximum.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Rehabilitation services	30% co-insurance after deductible		20 combined outpatient visits per Calendar Year maximum; Additional 10 combined outpatient visits per Calendar Year maximum; Additional 3-to-1 swap of Skilled Nursing Care for pre-approved treatment Plan.
	Facility	30% co-insurance after deductible	40% co-insurance after deductible	
	Physician			
	Habilitation services Facility	30% co-insurance after deductible		
	Physician	30% co-insurance after deductible	40% co-insurance after deductible	
	Skilled nursing care	30% co-insurance after deductible		Limited to the facility's semi-private room rate; limited to 60 days Calendar Year maximum
	Durable medical equipment	30% co-insurance after deductible	40% co-insurance after deductible	——————none——————
	Hospice service	No charge		——————none——————
If your child needs dental or eye care	Eye exam	Not covered		No coverage for routine eye exams.
	Glasses	Not covered		No coverage for glasses.
	Dental check-up	Not covered		No coverage for dental care.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-777-3575**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Employee Benefits Management Services, Inc. (EBMS) at 1-800-777-3575 or www.ebms.com. You may also 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/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,890
- **Patient pays** $2,650

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,250
Copays	$0
Coinsurance	$1,250
Limits or exclusions	$150
Total	**$2,650**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,610
- **Patient pays** $1,790

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,250
Copays	$0
Coinsurance	$460
Limits or exclusions	$80
Total	**$1,790**

HHS COVERAGE EXAMPLE CALCULATOR

- *This Plan has elected to use the U. S. Department of Health and Human Services (HHS) coverage calculator. These coverage examples are not an accurate reflection of the benefits under your plan.*

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.