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 1-877-304-0761 or visit us at www.ebmconline.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 www.ebmconline.com or call 1-877-304-0761 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$125/Individual or $250/family Out-net: $250/individual or $500/family	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 and primary care services 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?	Yes. $25 individual / $75 family for dental, if elected..	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $6600 individual / $13,200 family Out-net: $13,200 individual / $26,400 family	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?	Non-Precertification Penalties; Amounts over Usual and Reasonable, dental, vision benefits.	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.ebmconline.com or call 1-877-304-0761 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.

Questions: Call 1-877-304-0761 or visit us at www.ebmconline.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-877-304-0761 to request a copy.

Do you need a referral to see a specialist?	No.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Network Provider (You will pay the least)	Out-of-Network 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	$10 copay; 0% coinsurance	30% after deductible	
	Specialist visit	$10 copay; 0% coinsurance	30% after deductible	
	Preventive care/screening/ immunization	No charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	30% coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Generic drugs (Tier 1)	$10 copay then 0% coinsurance	$10 copay then 0% coinsurance	Mail order Copays: $20/$40/$80
	Preferred brand drugs (Tier 2)	$20 copay then 0% coinsurance	$20 copay then 0% coinsurance	
	Non-preferred brand drugs (Tier 3)	$40 copay then 0$ coinsurance	$40 copay then 0% coinsurance	
	Specialty drugs (Tier 4)	$150 copay then 0% coinsurance up to $1800 annual maximum out of pocket	$150 copay then 0% coinsurance up to $1800 maximum out of pocket.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	30% coinsurance after deductible	
	Physician/surgeon fees	0% coinsurance after deductible	30% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$75 copay then 0% coinsurance	$75 copay then 0% coinsurance	
	Emergency medical transportation	10% coinsurance after deductible	30% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$20 copay then 0% coinsurance	30% coinsurance after deductible.	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	30% coinsurance after deductible	Non pre-cert penalty $200
	Physician/surgeon fees	0% coinsurance after deductible	30% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance after deductible	30% coinsurance after deductible	
	Inpatient services	0% coinsurance after deductible	30% coinsurance after deductible	
If you are pregnant	Office visits	$10 copay then 0% coinsurance	30% coinsurance after deductible	Non Pre-Cert Penalty $200 if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean delivery
	Childbirth/delivery professional services	0% coinsurance after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance after deductible	100 visit maximum per calendar year
	Rehabilitation services	10% coinsurance after deductible	30% coinsurance after deductible	Physical therapy In Net: 30 visit maximum/ Out Net: 15 visit maximum per calendar year
	Habilitation services	10% coinsurance after deductible	30% coinsurance after deductible	
	Skilled nursing care	10% coinsurance after deductible	30% coinsurance after deductible	30 day maximum per calendar year
	Durable medical equipment	10% coinsurance after deductible	30% coinsurance after deductible	No coverage for charges in excess of the purchase price.
	Hospice services	10% coinsurance after deductible	30% coinsurance after deductible	
If your child needs dental or eye care	Children's eye exam	0% coinsurance	0% coinsurance	1 exam per calendar year
	Children's glasses	0% coinsurance	0% coinsurance	1 pair per calendar year.
	Children's dental check-up	0 % coinsurance	0% coinsurance	2 per calendar year if dental elected.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Acupuncture
- Long Term Care
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Hearing aids

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Dental Care (adult)
- Bariatric Surgery
- Chiropractic Care (20 visits)
- Private-Duty Nursing (30 visit calendar year maximum)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-877-304-0761. 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/ebsa, or the U.S. Department of Health and Human Services 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: www.ebmconline.com or by calling 1-877-304-0761.

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 1-877-304-0761.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-304-0761.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-304-0761
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-304-0761.

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

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	$125
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	10%

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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$125
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$135**

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

The plan's overall deductible	$125
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	10%

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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$125
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$79
The total Joe would pay is	**$224**

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

The plan's overall deductible	$125
Specialist copayment	$10
Hospital (facility) coinsurance	0%
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$125
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$135**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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