




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 1-866-401-3883. 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:
<b>What is the overall <u>deductible</u>?</b>	<b>Exclusive providers: Single coverage:</b> \$3,500; \$4,000; \$4,500; \$5,000; \$6,000; or \$7,000 <b>Family coverage:</b> 2 x single coverage <b>Non-Exclusive providers: Single coverage:</b> Not covered; <b>Family coverage:</b> Not covered	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. The following Exclusive <u>provider</u> services: <u>routine preventive care</u> , <u>Health Risk Screenings</u> ; and <u>preventive maintenance medications</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<b>Exclusive providers: Single coverage:</b> \$3,500; \$4,000; \$4,500; \$5,000; \$6,000; or \$7,000 <b>Family coverage:</b> 2 x single coverage <b>Non-Exclusive providers: Single coverage:</b> Not covered; <b>Family coverage:</b> Not covered	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges (unless balanced billing is prohibited), amounts over the allowable charge, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of <b>Exclusive providers in the ChoiceCare Provider Network (through Billings Clinic)</b> , see <a href="http://www.ebms.com">www.ebms.com</a> or call 1-866-401-3883.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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
		Exclusive Provider (You will pay the least)	Non-Exclusive 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	0% <u>coinsurance</u>	Not covered	None
	<u>Specialist</u> visit	0% <u>coinsurance</u>	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	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 for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	Not covered	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.ebms.com">www.ebms.com</a>	<b>Preventive maintenance medications:</b> Generic drugs	\$15 <u>copayment/ prescription, deductible waived</u> (retail pharmacy); \$15 <u>copayment/ prescription, deductible waived</u> (retail and mail order pharmacy)	Not covered	The medical deductible does not apply to <u>preventive maintenance medications</u> .  Coverage is limited to a 30-day supply (non-participating retail pharmacy) and up to a 90-day supply (participating retail and mail order pharmacy).  For more information regarding pharmacy benefit coverage, contact Navitus Customer Care toll free at 1 (866) 333-2757.
	Brand Name drugs – Formulary	\$45 <u>copayment/ prescription, deductible waived</u> (retail pharmacy); \$90 <u>copayment/ prescription, deductible waived</u> (retail and mail order pharmacy)	Not covered	
	Brand Name drugs – Non-Formulary	35% <u>coinsurance/ prescription, deductible waived</u> (retail pharmacy or mail order pharmacy)	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.ebms.com](http://www.ebms.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Exclusive Provider (You will pay the least)	Non-Exclusive Provider (You will pay the most)	
	Generic drugs	\$0 <u>copayment/ prescription</u> (retail pharmacy or mail order pharmacy)	Not covered	<p><u>Prescription drugs</u> (other than preventive maintenance medications) will be payable after the medical <u>deductible</u>.</p> <p>Coverage is limited to a 30-day supply (retail pharmacy) and up to a 90-day supply (mail order pharmacy).</p> <p>For more information regarding pharmacy benefit coverage, contact Navitus Customer Care toll free at 1 (866) 333-2757.</p> <p><u>Specialty drug medications</u> will be payable after the medical <u>deductible</u>.</p> <p><u>Specialty drugs</u> must be purchased through Lumicera Health Services. For more information call (855) 847-3553.</p>
	Brand Name drugs – Formulary	\$0 <u>copayment/ prescription</u> (retail pharmacy or mail order pharmacy)	Not covered	
	Brand Name drugs – Non-Formulary	0% <u>coinsurance/ prescription</u> (retail pharmacy or mail order pharmacy)	Not covered	
	<u>Specialty drugs</u>	0% <u>coinsurance / prescription</u>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u> <u>Medical Emergency</u>	0% <u>coinsurance</u>		Services for Medical Non-Emergency Care will be payable at the 70 <sup>th</sup> percentile of the allowable charge and only when provided by an <u>Exclusive provider</u> .
	<u>Medical Non-Emergency Care</u>	0% <u>coinsurance</u>	Not covered	
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>		Services for a medical non-emergency transport will be payable at the 70 <sup>th</sup> percentile of the allowable charge and will be payable at the <u>Exclusive provider coinsurance level</u> .
	<u>Urgent care</u>	0% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Exclusive Provider (You will pay the least)	Non-Exclusive Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	Not covered	Coverage is limited to the facility's average semi-private room rate.
	Physician/surgeon fees	0% <u>coinsurance</u>	Not covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	0% <u>coinsurance</u>	Not covered	None
	Office visits	0% <u>coinsurance</u>	Not covered	None
	Inpatient services	0% <u>coinsurance</u>	Not covered	None
<b>If you are pregnant</b>	Office visits	0% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	0% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	0% <u>coinsurance</u>	Not covered	Coverage is limited to the facility's average semi-private room rate.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	0% <u>coinsurance</u>	Not covered	Coverage is limited to 40 visits maximum per calendar year.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	Not covered	None
	<u>Habilitation services</u>	0% <u>coinsurance</u>	Not covered	
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	Not covered	Coverage limited to the facility's average semi-private room rate. Coverage limited to 90 days maximum per calendar year.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	Not covered	None
	<u>Hospice services</u>	0% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Exclusive Provider (You will pay the least)	Non-Exclusive Provider (You will pay the most)	
<b>If your child needs dental or eye care</b>	Children's eye exam	No routine vision coverage		None
	Children's glasses	No routine vision coverage		None
	Children's dental check-up	No routine dental coverage		Dental coverage is optional and requires a separate premium amount and separate enrollment 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](#).)**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

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| <ul style="list-style-type: none"> <li>• Acupuncture and Chiropractic care (limited to \$500 combined benefit maximum per calendar year)</li> </ul> |
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\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ebms.com](http://www.ebms.com).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 on how 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: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthcarereform](http://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 1-866-401-3883.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-401-3883.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-401-3883.

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-866-401-3883.

*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** \$3,500
- **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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,560</b>

**Managing Joe's Type 2 Diabetes**

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

- **The plan's overall deductible** \$3,500
- **Specialist 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles*</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,520</b>

**Mia's Simple Fracture**

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

- **The plan's overall deductible** \$3,500
- **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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

\* Note: The \$3,500 Exclusive provider deductible Option has been used to calculate these Coverage Examples for the purposes of this Summary of Benefits and Coverage document.