




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:
<p>What is the overall deductible?</p>	<p>LOW OPTION Participating providers: Single coverage: \$2,000 per person Family coverage : 2 x single coverage per family unit Non-participating providers: Single coverage: \$4,000 per person Family coverage: 2 x single coverage per family unit</p> <p>HIGH OPTION Participating providers: Single coverage: \$3,000 per person Family coverage: 2 x single coverage per family unit Non-participating providers: Single coverage: \$6,000 per person Family coverage: 2 x single coverage per family unit</p>	<p>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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. The following participating <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>.</p>	<p>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 https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>LOW AND HIGH OPTIONS: Participating providers: Single coverage: \$5,000 per person Family coverage: \$10,000 per family unit (and will not exceed \$7,000 per any one individual with family coverage and only when using a participating <u>provider</u>); Non-participating providers: Single coverage: \$10,000 per person Family coverage: \$20,000 per family unit</p>	<p>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.</p>

<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><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.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. For a list of participating providers, see www.ebms.com or call 1-866-401-3883.</p>	<p>This <u>plan</u> uses a provider <u>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.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

NOTE: The “70/30” **Coinsurance** Option has been used as the example in reflecting “What You Will Pay” column for purposes of this Summary of Benefits and Coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating 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	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	<u>Specialist</u> visit	30% <u>coinsurance</u>	45% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge	45% <u>coinsurance</u>	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)	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	45% <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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.ebms.com</p>	<p>Preventive maintenance medications: Generic drugs</p>	<p>\$15 <u>copayment/ prescription, deductible waived</u> (retail pharmacy); \$15 <u>copayment/ prescription, deductible waived</u> (retail and mail order pharmacy)</p>	Not covered	<p><u>The medical deductible does not apply to preventive maintenance medications.</u></p> <p>Coverage is limited to a 30-day supply (non-preferred retail pharmacy) and up to a 90-day supply (preferred retail and mail order pharmacy).</p> <p>For more information regarding pharmacy benefit coverage, contact Navitus Customer Care toll free at 1 (866) 333-2757.</p>
	Brand Name drugs – Formulary	<p>\$45 <u>copayment/ prescription, deductible waived</u> (retail pharmacy); \$90 <u>copayment/ prescription, deductible waived</u> (retail and mail order pharmacy)</p>	Not covered	<p>For more information regarding pharmacy benefit coverage, contact Navitus Customer Care toll free at 1 (866) 333-2757.</p>
	Brand Name drugs – Non-Formulary	<p>35% <u>coinsurance/ prescription, deductible waived</u> (retail pharmacy or mail order pharmacy)</p>	Not covered	<p>For questions regarding the mail order pharmacy, call Costco Mail Order Pharmacy at 800-607-6861</p>
	Generic drugs	<p>\$15 <u>copayment/ prescription</u> (retail pharmacy); \$15 <u>copayment/ prescription</u> (retail and mail order pharmacy)</p>	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 (non-preferred retail pharmacy) and up to a 90-day supply (preferred retail and mail order pharmacy).</p>
	Brand Name drugs – Formulary	<p>\$45 <u>copayment/ prescription</u> (retail pharmacy); \$90 <u>copayment/ prescription</u> (retail and mail order pharmacy)</p>	Not covered	<p>For more information regarding pharmacy benefit coverage, contact Navitus Customer Care toll free at 1 (866) 333-2757. For questions regarding the mail order pharmacy, call Costco Mail Order Pharmacy at 800-607-6861</p>
	Brand Name drugs – Non-Formulary	<p>35% <u>coinsurance/ prescription</u> (retail pharmacy or mail order pharmacy)</p>	Not covered	

* 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	<u>Specialty drugs</u>	30% <u>coinsurance / Prescription</u>	Not covered	Specialty drug medications will be payable after the medical deductible. Specialty drugs must be purchased through Lumicera Health Services. For more information call (855) 847-3553.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u> <u>Medical Emergency</u>	30% <u>coinsurance</u>		Services for Medical Non-Emergency Care will be payable at the 70 th percentile of the allowable charge for both participating and non-participating providers.
	<u>Medical Non-Emergency Care</u>	30% <u>coinsurance</u>	45% <u>coinsurance</u>	
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>		Services for medical non-emergency transport will be payable at the 70 th percentile of the allowable charge for both participating and non-participating providers.
	<u>Urgent care</u>	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	45% <u>coinsurance</u>	Coverage is limited to the facility's average semi-private room rate.
	Physician/surgeon fees	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Office visits	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
If you are pregnant	Office visits	30% <u>coinsurance</u>	45% <u>coinsurance</u>	<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	30% <u>coinsurance</u>	45% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	45% <u>coinsurance</u>	Coverage is limited to the facility's average semi-private room rate.

* 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	45% <u>coinsurance</u>	Coverage is limited to 40 visits maximum per calendar year.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	<u>Habilitation services</u>	30% <u>coinsurance</u>	45% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	45% <u>coinsurance</u>	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>	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	<u>Hospice services</u>	30% <u>coinsurance</u>	45% <u>coinsurance</u>	None
If your child needs dental or eye care	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"> • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Hearing aids (Adult) 	<ul style="list-style-type: none"> • Infertility treatment • Long term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Acupuncture and Chiropractic care (limited to \$500 combined benefit maximum per calendar year) 		

* 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. 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. 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 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. 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 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 at'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** \$2,000
- **Specialist coinsurance** 30%
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$3,300
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$4,810

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** \$2,000
- **Specialist coinsurance** 30%
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles*</u>	\$2,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,900

Mia's Simple Fracture

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

- **The plan's overall deductible** \$2,000
- **Specialist coinsurance** 30%
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,910

* Note: The "70/30" Coinsurance Option and a Single Coverage Low Option (\$2,000 Exclusive provider deductible) has been used to calculate these Coverage Examples for the purposes of this Summary of Benefits and Coverage document.