



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, visit myEBbenefits.com or by calling 1-866-499-5168. 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 myEBbenefits.com or call 1-866-499-5168 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$1,500 person / \$3,000 family In-network \$3,000 person / \$6,000 family Out-of-network	Generally, you must pay all 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> services 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$6,800 person / \$13,600 family In-network \$13,600 person / \$27,200 family Out-of-network Combined medical/behavioral and pharmacy out-of-pocket limit	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.
What is not included in the <u>out-of-pocket limit</u>?	Penalties, <u>premiums</u> , <u>balance billing</u> charges, 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> .
Will you pay less if you use a <u>network provider</u>?	Yes. See myEBbenefits.com or call 1-866-499-5168 for a list of <u>network providers</u> .	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 charge</u> 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> .
	All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	25% <u>coinsurance</u> ; <u>deductible</u> waived	40% <u>coinsurance</u> after deductible	None
	<u>Specialist</u> visit	25% <u>coinsurance</u> ; <u>deductible</u> waived	40% <u>coinsurance</u> after deductible	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> waived	40% <u>coinsurance</u> after deductible	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u> ; <u>deductible</u> waived office setting; 25% <u>coinsurance</u> outpatient setting No charge, Deductible Waived, Independent lab	40% <u>coinsurance</u> after deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u> ; <u>deductible</u> waived office setting; 25% <u>coinsurance</u> outpatient setting	40% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required for MRI/MRA/PET scans.
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at www.express-scripts.com .	Generic drugs (Tier 1)	Retail (per 30-day supply): You pay \$10; Retail (per 90-day supply): You pay \$30; Home Delivery (per 90-day supply): You pay \$25; Deductible Waived	Retail: You pay 50%; Home Delivery: Not covered Deductible Waived	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply for most Specialty drugs; certain Specialty drugs may be allowed up to a 90-day supply. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. For drugs in the ESI Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	Retail (per 30-day supply): You pay 30% up to a maximum of \$50; Retail (per 90-day supply): You pay 30% up to a maximum of \$150; Home Delivery (per 90-day supply): You pay 30% up to a maximum of \$125; Deductible Waived	Retail: You pay 50%; Home Delivery: Not covered Deductible Waived	
	Non-preferred brand drugs (Tier 3)	Retail (per 30-day supply): You pay 40% up to a maximum of \$100; Retail (per 90-day supply): You pay 40% up to a maximum of \$300; Home Delivery (per 90-day supply): You pay 40% up to a maximum of \$250; Deductible Waived	Retail: You pay 50%; Home Delivery: Not covered Deductible Waived	
	<u>Specialty drugs</u> (Tier 4)	Retail (per 30-day supply): You pay 40% up to a maximum	Retail: You pay 50%; Home Delivery: Not covered Deductible Waived	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
		of \$400; Home Delivery: You pay 40% up to a maximum of \$400; Deductible Waived		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required.
	Physician/surgeon fees	25% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> per visit; 25% <u>coinsurance</u> ; <u>deductible</u> waived	\$200 <u>copay</u> per visit; 25% <u>coinsurance</u> ; <u>deductible</u> waived	<u>Copay</u> may be waived if admitted
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	In-network <u>deductible</u> applies to Out-of-network benefits
	<u>Urgent care</u>	25% <u>coinsurance</u> ; <u>deductible</u> waived	\$50 <u>copay</u> per day; 25% <u>coinsurance</u> ; <u>deductible</u> waived	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required.
	Physician/surgeon fees	25% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <u>coinsurance</u> ; deductible waived Office visits; 25% <u>coinsurance</u> other outpatient services	40% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required for Partial hospitalization.
	Inpatient services	25% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	No charge; deductible waived	40% <u>coinsurance</u> after deductible	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	
	Childbirth/delivery facility services	25% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	60 maximum visits per calendar year; <u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	25% <u>coinsurance</u> ; deductible waived	40% <u>coinsurance</u> after deductible	60 maximum visits per calendar year combined with Chiropractic care; Visit limits will not apply to behavioral health.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	<u>Habilitation services</u>	25% <u>coinsurance</u> ; <u>deductible</u> waived	40% <u>coinsurance</u> after deductible	
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u> after deductible	90 maximum days per calendar year; <u>Preauthorization</u> is required.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required for DME in excess of \$1,500 for purchases or all rentals.
	<u>Hospice service</u>	25% <u>coinsurance</u>	40% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

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|-----------------------|--|----------------------------|
| • Acupuncture | • Infertility treatment | • Routine eye care (Adult) |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult) | • Private-duty nursing | |

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

- Chiropractic care - 60 visit combined with PT/OT/ST
- Hearing aids - \$5,000 per 48 months (In-network only)

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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.HealthCare.gov 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 Standard? 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 1-866-499-5168.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-499-5168.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-499-5168.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-866-499-5168.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-499-5168.

Samoaan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-499-5168.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-499-5168.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-499-5168.

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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> <u>coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal 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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,800
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$4,320

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> <u>coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$40
The total Joe would pay is	\$360

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist</u> <u>coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic tests (*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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$1,710

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: myEBbenefits.com or call 1-866-499-5168.