



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, log into www.ebcflex.com or call 1-800-346-2126. 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.healthcare.gov/SBC-GLOSSARY or call 1-800-346-2126 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers. This plan is a Health Reimbursement Arrangement (HRA) that reimburses individual billed insurance premium expenses.
Are there services covered before you meet your deductible ?	Yes, all Internal Revenue Code Section 213(d) medical expenses are eligible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services for this plan. Check your major medical plan's SBC for other deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	No.	This plan does not use a provider network . You can receive covered services from any provider .
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Specialist visit	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Preventive care/screening/immunization	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
If you have a test	Diagnostic test (x-ray, blood work)	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Imaging (CT/PET scans, MRIs)	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ebcflex.com	Generic drugs	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Preferred brand drugs	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Non-preferred brand drugs	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Specialty drugs	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Physician/surgeon fees	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
If you need immediate medical attention	Emergency room care	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Emergency medical transportation	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Urgent care	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Physician/surgeon fees	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Inpatient services	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
If you are pregnant	Office visits	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Childbirth/delivery professional services	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Childbirth/delivery facility services	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
If you need help recovering or have other special health needs	Home health care	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Rehabilitation services	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Habilitation services	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Skilled nursing care	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Durable medical equipment	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Hospice services	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
If your child needs dental or eye care	Children's eye exam	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Children's glasses	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense
	Children's dental check-up	\$0 until account balance is exhausted.	Must be an eligible IRC Section 213(d) expense

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 .)		
• Cosmetic surgery	• Long-term care	• Weight loss programs

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

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|-----------------------|--|---------------------------------|
| • Acupuncture | • Hearing aids | • Private-duty nursing |
| • Bariatric surgery | • Infertility treatment | • Routine eye care (Adult) |
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Dental care (Adult) | | • Any § 213(d) eligible expense |

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: 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.cco.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: ,Employee Benefits Corporation at 1-800-346-2126,

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? No

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:

None

_____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	\$0
■ Specialist	\$0
■ Hospital (facility)	0%
■ Other	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*)

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

Cost Sharing	
Deductibles	\$
Copayments	\$
Coinsurance	\$
What isn't covered	
Limits or exclusions	None
The total Peg would pay is	Costs exceeding HRA balance

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist	\$0
■ Hospital (facility)	0%
■ Other	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*)

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

Cost Sharing	
Deductibles	\$
Copayments	\$
Coinsurance	\$
What isn't covered	
Limits or exclusions	None
The total Joe would pay is	Costs exceeding HRA balance

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist	\$0
■ Hospital (facility)	0%
■ Other	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$
Copayments	\$
Coinsurance	\$
What isn't covered	
Limits or exclusions	None
The total Mia would pay is	Costs exceeding HRA balance