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 1-866-887-4115 or visit www.ebms.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 https://www.healthcare.gov/sbc-glossary or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating providers $2,000 individual / $6,000 family; Non-participating providers Not Covered	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. Medical emergency care services (through the emergency room) and urgent care services; and the following participating provider services: outpatient hospital and outpatient physician's services, physician office visits, surgery performed in the office, injections (including allergy injections), diagnostic x-ray and lab testing, advanced radiological imaging services, durable medical equipment, orthotics, prosthetics, chiropractic services, ostomy supplies, outpatient short-term rehabilitation therapy services, and preventive 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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Participating providers $6,000 individual / $10,000 family; Non-participating providers Not Covered	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?	Deductibles, copayments, premiums, balance-billing charges (unless balanced billing is prohibited), amounts over the allowable charge, and health care this plan doesn't cover.	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. For a list of participating providers, see the following websites: www.aetna.com/asa or www.ebms.com, or call toll-free 1-866-887-4115.	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.
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
		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	$50 copayment/visit; deductible does not apply	Not covered	A primary care physician "PCP" is defined as a general practitioner, family practitioner, general internist (internist whose practice is 70% general medicine), nurse practitioner, physician's assistant or pediatrician. An OB/GYN will be considered a "specialist."
	Office visits through the El Paso County Employee Health Center ("Clinic")	$10 copayment/visit; deductible does not apply	Not covered	
	Specialist visit	$50 copayment/visit; deductible does not apply	Not covered	
	Office visits through the El Paso County Employee Health Center ("Clinic")	$10 copayment/visit; deductible does not apply	Not covered	
	Preventive care/screening/ Immunization Routine well care visits through the El Paso County Employee Health Center ("Clinic")	$10 Clinic copayment /visit; deductible does not apply	Not covered	None
	All other providers	$40 copayment /visit; deductible does not apply	Not covered	

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 have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance; deductible does not apply	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com or toll-free at 1 (855) 738-1153.	Generic drugs	$6 copayment/ prescription (retail pharmacy) and $15 copayment/ prescription (90-day supply)	Not covered	Coverage is limited to a 30-day supply (retail pharmacy) or a 90-day supply (retail pharmacy or mail order pharmacy).
	Preferred brand drugs	$30 copayment/ prescription (retail pharmacy) and $75.00 copayment/ prescription (90-day supply)	Not covered	
	Non-preferred brand drugs	$50 copayment/ prescription (retail pharmacy) and $125.00 copayment/ prescription (90-day supply)	Not covered	
	Specialty drugs Preferred	$100 copayment/ prescription (specialty pharmacy)	Not covered	
	Non-Preferred	$200 copayment/ prescription (specialty pharmacy)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after $250 copayment/visit; deductible does not apply	Not covered	The outpatient facility copayment will apply as long as the services billed include one or more of the facility room charges: operating room, recovery room, procedures room, treatment room, and observation room.
	Physician/surgeon fees	25% coinsurance; deductible does not apply	Not covered	None

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 need immediate medical attention	Emergency room care Medical emergency care	$200 copayment/visit; deductible does not apply		The emergency room copayment will be waived if admitted to the hospital directly from the emergency room. *Medical non-emergency care will be payable subject to the medical emergency care benefit if the covered person calls the Nurse Line and is referred to the emergency room.
	Medical non-emergency care	Not covered*		
	Emergency medical transportation	25% coinsurance		Pre-authorization with the claims administrator is required for non-emergent transport. Contact EBMS, Inc. toll-free at 1-866-887-4115 to pre-authorize non-emergent transport.
	Urgent care	$100 copayment/visit; deductible does not apply	$100 copayment/visit; deductible does not apply	The urgent care copayment will be waived if admitted to the hospital or to the emergency room directly from the urgent care. The urgent care copayment will include both facility and physician charges.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance and $500 copayment, per admission	Not covered	Coverage is limited to the facility's semi-private room rate.
	Physician/surgeon fees	25% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment /visit; deductible does not apply	Not covered	None
	Inpatient services			
	Facility	25% coinsurance and $500 copayment, per admission	Not covered	None
	Physician	25% coinsurance	Not covered	

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 are pregnant	Office visits Initial office visit to confirm pregnancy: Physician's office visits in addition to the global maternity fee (when performed by an OB/GYN or specialist)	$50 copayment /visit; deductible does not apply $50 copayment /visit; deductible does not apply	Not covered Not covered	Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	Not covered	None
	Childbirth/delivery facility services	25% coinsurance and $500 copayment, per admission	Not covered	Coverage is limited to the facility's semi-private room rate.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not covered	Coverage is limited to 60 days maximum per calendar year.
	Rehabilitation services	$20 copayment /visit; deductible does not apply	Not covered	Outpatient short-term rehabilitation therapy is limited to a 60-day combined benefit maximum for all therapies per calendar year. Outpatient short-term rehabilitation therapy includes the following: cardiac rehabilitation, physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy.
	Habilitation services	$20 copayment /visit; deductible does not apply	Not covered	
	Skilled nursing care	25% coinsurance	Not covered	Coverage is limited to 60 days maximum per calendar year. Limited to the facility's semi-private room rate.
	Durable medical equipment	No charge	Not covered	The FusionHealth program must be utilized for treatment of sleep apnea, including devices for the treatment of sleep apnea. For more information, contact FusionHealth toll-free at 1 (877) 615-7257 (option 2).
	Hospice services	25% coinsurance	Not covered	None

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 your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Vision coverage is available and administered by EyeMed.
	Children's glasses	Not covered	Not covered	Vision coverage is available and administered by EyeMed.
	Children's dental check-up	Not covered	Not covered	Dental coverage is available and administered by Delta Dental.

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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric Surgery
- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information, contact **EBMS at 1-800-777-3575** or these agencies: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/ or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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: EBMS at 1-800-777-3575 or the DOL's Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. Contact your state's program if available at: http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 1-866-887-4115.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-887-4115.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-866-887-4115.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-887-4115.

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** **$2,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$900
Coinsurance	$2,840
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,800**

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**
- **Primary care physician copayment** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$1,220
Coinsurance	$430
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,005**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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	$565
Copayments	$430
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,195**

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

NOTICE OF NONDISCRIMINATION COLORADO

Your health plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your health plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact your Human Resources Department. If you believe that your health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator:

El Paso County Employee Benefits Division
Attention:
Renee' Mabe
2880 International Circle
Colorado Springs, CO 80910
1 (719) 520-7420,
Fax: 1 (719) 520-7497
reneemabe@elpasoco.com

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You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

SPANISH:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (719)-520-7420.

VIETNAMESE:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (719)-520-7420.

CHINESE:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1 (719)-520-7420。

KOREAN:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (719)-520-7420 번으로 전화해 주십시오.

RUSSIAN:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (719)-520-7420.

AMHARIC:
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1 (719) 520-7420.

ARABIC:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 (719) 520-7420 (رقم هاتف الصم والبكم)

GERMAN:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (719) 520-7420.

FRENCH:
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (719) 520-7420.

NEPALI:
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1 (719) 520-7420.

TAGALOG:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (719)-520-7420.

JAPANESE:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (719) 520-7420。

CUSHITE provided in the Oromo language):
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1 (719) 520-7420.

PERSIAN (written translated tagline is provided in the Farsi language):
AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1 (719) 520-7420.

Kru*†, Ibo*, Yoruba*:
Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1 (719) 520-7420.