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, go to www.ggusd.us/insurance.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at www.ggusd.us/insurance .

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300 person/$900 family** Does not apply to federally-required preventive care. Out-of-network coinsurance and copayments don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services. The **deductible** starts over on January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes.	All covered services require you to meet your deductible before the plan makes payment, with the exception of federally required preventive care. Preventive care is covered 100% regardless of your deductible balance.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**Network Provider:** $2,500 individual/$7,500 family **Non-Network Provider:** $3,500 individual/$12,700 family	The **out-of-pocket limit** is the most you could pay during a coverage period (calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The out-of-pocket maximums do not apply to or include amounts in excess of allowed amount.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, 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 network providers, see www.ebam.com or call 1-855-322-7606	Your **coinsurance** increases when you go to an out-of-network provider; you may also be **balance billed** as you are responsible for any charges exceeding the **allowed amount**.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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	$25 copay/visit; 20% coinsurance	$25 copay/visit; 30% coinsurance; amount in excess of allowed amount	----------NONE----------
	Specialist visit	$25 copay/visit; 20% coinsurance	$25 copay/visit; 30% coinsurance; amount in excess of allowed amount	Chiropractor and Acupuncture visits included.
	Preventive care/screening/ immunization	No charge for federally required preventive services	$25 copay/visit; 30% coinsurance; amount in excess of allowed amount	----------NONE----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance; amount in excess of allowed amount	----------NONE----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance; amount in excess of allowed amount	----------NONE----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.americanhealthcare.com	Most Generic & Selected OTC Drugs	$5 copay/prescription	$5 copay/prescription; amount in excess of allowed amount	----------NONE----------
	Brand Name & Selected Generic Drugs	$10 copay/prescription	$10 copay/prescription; amount in excess of allowed amount	----------NONE----------
	Selected Drugs within each therapeutic class	$35 copay/prescription	$35 copay/prescription; amount in excess of allowed amount	----------NONE----------
	Specialty drugs	$5-$35 copay/prescription	$5-$35 copay/prescription; amount in excess of allowed amount	----------NONE----------
	Diabetic Supplies	20% of contracted fee	20% of contracted fee; amount in excess of allowed amount	Insulin co-pay based on formulary tier.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance of $600/day; amount in excess of allowed amount	----------NONE----------
	Physician/surgeon fees	20% coinsurance	30% coinsurance; amount in excess of allowed amount	----------NONE----------

[* For more information about limitations and exceptions, see the plan or policy document at www.ggusd.us/insurance.]

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	$100 copay/visit; 20% coinsurance	$100 copay/visit; 20% coinsurance for Emergency Medical Condition; amount in excess of allowed amount	Copay waived if admitted. Non-Emergency use of out-of-network provider: 30% coinsurance of $600 plus amount in excess of allowed amount.
	Emergency medical transportation	20% coinsurance	20% coinsurance; amount in excess of allowed amount	----------NONE----------
	Urgent care	$25 copay/visit; 20% coinsurance	$25 copay/visit; 30% coinsurance; amount in excess of allowed amount	----------NONE----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance of $600/day; amount in excess of allowed amount	----------NONE----------
	Physician/surgeon fees	20% coinsurance	30% coinsurance; amount in excess of allowed amount	----------NONE----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; 20% coinsurance	$25 co-pay/visit; 30% coinsurance; amount in excess of allowed amount	----------NONE----------
	Inpatient services	20% coinsurance	Physicians: 30% coinsurance; amount in excess of allowed amount Facility: 30% coinsurance of $600/day; amount in excess of allowed amount	See “Medical Limitations and Exclusions” in Summary Plan Description.
If you are pregnant	Office visits	$25 copay/pregnancy; 20% coinsurance	$25 copay/pregnancy; 30% coinsurance; amount in excess of allowed amount	Single $25 copay applies to routine pregnancy visits only. Benefits limited to covered Employee or covered Dependent spouse only.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance; amount in excess of allowed amount	Benefits limited to covered Employee or covered Dependent spouse only.
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance of $600/day; amount in excess of allowed amount	Benefits limited to covered Employee or covered Dependent spouse only.

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 help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance; amount in excess of allowed amount	----------NONE----------
	Rehabilitation services	20% coinsurance	30% coinsurance; amount in excess of allowed amount	See "Eligible Medical Expenses" in Summary Plan Description.
	Habilitation services	Not covered	Not covered	----------NONE----------
	Skilled nursing care	20% coinsurance	30% coinsurance of $600/day; amount in excess of allowed amount	----------NONE----------
	Durable medical equipment	20% coinsurance	30% co-insurance; amount in excess of allowed amount	See "Eligible Medical Expenses" in Summary Plan Description.
	Hospice services	20% coinsurance	30% coinsurance of $600/day; amount in excess of allowed amount	----------NONE----------
If your child needs dental or eye care	Children's eye exam	No charge	$25 copay/visit; 30% coinsurance; amount in excess of allowed amount	Applies only to vision screening under federally-required preventive care.
	Children's glasses	Not covered	Not covered	----------NONE----------
	Children's dental check-up	Not covered	Not covered	----------NONE----------

[* For more information about limitations and exceptions, see the plan or policy document at www.ggusd.us/insurance.]

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
- Bariatric surgery (except when criteria has been met)
- Dental care
- Glasses
- Hearing Aids
- Habilitation services
- Long-term care
- Routine foot care
- Weight loss programs
- Foot Orthotics

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

- Acupuncture
- Chiropractic care
- Infertility treatment (limited; see plan documents)
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information, contact the plan at 714-663-6523.

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:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: EBA&M by phone at 1-855-322-7606 or by mail at 18002 Cowan, Irvine, CA 92614.

Does this plan provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." 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. **This plan or policy does provide minimum essential coverage.**

Does this plan meet the Minimum Value Standards?

The Affordable Care Act established a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This plan does meet the minimum value standard for the benefits is provides.**

Language Access Services:

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.ggusd.us/insurance.]

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.

Having a Baby
(**9 months** of in-network pre-natal care and a normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays: $6,080**
- **Patient pays: $1,460**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total Example Cost	**$7,540**

In this example, patient pays:

Deductibles	$300
Copayments	$50
Coinsurance	$960
Limits or exclusions	$150
The total patient would pay is	**$1,460**

Managing type 2 Diabetes
(**a year** of routine in-network care of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays: $3,930**
- **Patient pays: $1,470**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total Example Cost	**$5,400**

In this example, patient pays:

Deductibles	$300
Copayments	$970
Coinsurance	$130
Limits or exclusions	$40
The total patient would pay is	**$1,440**

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

- **Amount owed to providers: $3,590**
- **Plan pays: $2,575**
- **Patient pays: $1,015**

Sample care costs:

Emergency room charges	$1,500
Radiology	$300
Medical Equipment and Supplies	$1,200
Office Visits and Procedures	$400
Prescriptions	$150
Vaccines, other preventive	$40
Total Example Cost	**$3,590**

In this example, patient pays:

Deductibles	$300
Copayments	$175
Coinsurance	$540
Limits or exclusions	$0
The total patient would pay is	**$1,015**

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