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 888-326-7240. 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?	**Tier 1 Providers**: $900 per plan participant, $1,800 per family unit. **Tier 2 Providers**: $1,250 per plan participant, $2,500 per family unit. **Tier 3 Providers**: $1,250 per plan participant, $2,500 per family unit. Deductible starts over each **OCTOBER 1.**	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. Preventive care, diagnostic lab, Tier 1/Tier 2: outpatient/office rehab, outpatient office visits and office visits, and urgent care are covered before you meet your deductible. *Also, covered services incurred at a **School District of Osceola County (SDOC) Center for Employee Health** or incurred due to a **Member Advocacy** recommendation are not subject to 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. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 per plan participant for prescription drugs. *Does not apply to generic drugs or preferred pharmacy brand drugs.*	Yes: You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Tier 1 Providers** including preferred pharmacy expenses: $5,000 per plan participant, $10,000 per family unit. **Tier 2 Providers** including non-preferred pharmacy expenses: $6,300 per plan participant, $13,600 per family unit. **Tier 3 Providers**: $6,300 per plan participant, $13,600 per family unit.	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?	Pre-certification penalties, prescription drug DAW penalties & discounts/coupons, premiums, balance-billing charges (unless balance-billing is prohibited), and health care this plan doesn't cover. The out-of-pocket limit starts over each **OCTOBER 1.**	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. See https://etrx.ehsppo.com/ETRXMemberPortal.aspx?EmployerID=32820 or call *Member Advocacy* at 844-297-0747, for a list of Tier 1 or Tier 2 *(preferred)* providers.	This plan offers *preferred* provider opportunities. You will pay less if you use a Tier 1 or Tier 2 *(preferred)* provider. You will pay more if you use a Tier 3 (non-*preferred)* provider, and you might receive a bill from a Tier 3 provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your Tier 1 or Tier 2 *(preferred)* provider might use a Tier 3 (non-*preferred)* provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
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 *There is No cost for covered services incurred at an **SDOC Center for Employee Health.** Services incurred due to a **Member Advocacy** recommendation are not subject to deductible.*			Limitations, Exceptions, & Other Important Information* *Services incurred by an Advent Health provider are not eligible for reimbursement (except medically necessary emergency room care)*
		Tier 1 Providers (You will pay the least)	Tier 2 Providers (You will pay more)	Tier 3 Providers (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	$20 copayment per visit; deductible does not apply	$40 copayment per visit; deductible does not apply	30% coinsurance	The copayment applies per visit and includes lab & x-ray, injections, allergy, and office surgery. The copayment also applies to lab/x-ray and durable medical equipment (except CPAPs), related to the visit but billed by a different provider and incurred within five days of the visit.
	Specialist visit	$40 copayment per visit; deductible does not apply	$80 copayment per visit; deductible does not apply	30% coinsurance	
	Preventive care/screening/ immunization	No cost	No cost	No cost	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay.
If you have a test	Diagnostic test - Lab	$10 copayment per visit; deductible does not apply	30% coinsurance; deductible does not apply	30% coinsurance; deductible does not apply	The first colonoscopy and the first mammogram each plan year is available at No cost. Imaging services may be available at no cost through *Green Imaging, LLC;* contact www.greenimaging.net. *Pre-certification is required prior to imaging services (not performed by Green Imaging, LLC), and prior to outpatient surgery (diagnostic colonoscopy), to avoid a penalty.*
	Diagnostic test - X-ray	30% coinsurance	30% coinsurance	30% coinsurance	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	30% coinsurance	30% coinsurance	

* 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 *There is No cost for covered services incurred at an **SDOC Center for Employee Health.** Services incurred due to a **Member Advocacy** recommendation are not subject to deductible.* **Tier 1 Providers (You will pay the least)**	**Tier 2 Providers (You will pay more)**	**Tier 3 Providers (You will pay the most)**	**Limitations, Exceptions, & Other Important Information*** *Services incurred by an Advent Health provider are not eligible for reimbursement (except medically necessary emergency room care)*
If you need drugs to treat your illness or condition. For more information contact https://www.ventegra.com/		**Preferred Pharmacy**		**Non-Preferred Pharmacy**	The prescription drug deductible applies to non-preferred pharmacy brand drugs*. Copayments *per prescription.* Retail drugs are available up to a 91-day supply per prescription. Specialty drugs are limited to a 30-day supply per prescription. There is no mail order pharmacy option. Brand drugs may also be available at no cost through the ElectRx International Mail Order Program. Contact https://www.electrx.com/ for more information.
	Generic drugs 30-day supply 31 to 60-day supply 61 to 91-day supply	 $6 copayment $12 copayment $18 copayment		 $10 copayment $20 copayment $30 copayment	
	Formulary brand drugs 30-day supply 31 to 60-day supply 61 to 91-day supply	 $45 copayment $90 copayment $135 copayment		 *20% copayment ($75 max) *20% copayment ($150 max) *20% copayment ($225 max)	
	Non-formulary brand drugs 30-day supply 31 to 60-day supply 61 to 91-day supply	 50% copayment ($150 max) 50% copayment ($300 max) 50% copayment ($450 max)		 *50% copayment ($200 max) *50% copayment ($400 max) *50% copayment ($600 max)	*For a current list of preferred and non-preferred pharmacies contact Ventegra at*: https://www.ventegra.com/. Prescription drugs obtained through a Pharmacy that is not part of the *Ventegra Nationwide Network* are not eligible for reimbursement.
	Specialty drugs	50% copayment ($200 max)		Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	30% coinsurance	30% coinsurance	*Pre-certification is required prior to outpatient surgery to avoid a penalty.*
	Physician/surgeon fees	30% coinsurance	30% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance *(subject to Tier 1 deductible and out-of-pocket limit)*			*Pre-certification subsequent to an admission from the emergency room is required to avoid a penalty.*
	Emergency medical transportation	30% coinsurance *(subject to Tier 1 deductible and out-of-pocket limit)*			None.
	Urgent care	$45 copayment per visit; deductible does not apply	$45 copayment p er visit; deductible does not apply	30% coinsurance	The copayment includes all services incurred during the visit and billed by the same provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	30% coinsurance	30% coinsurance	*Pre-certification is required prior to inpatient admissions to avoid a penalty.*
	Physician/surgeon fees	30% coinsurance	30% coinsurance	30% coinsurance	

* 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 *There is No cost for covered services incurred at an **SDOC Center for Employee Health.** Services incurred due to a **Member Advocacy** recommendation are not subject to deductible.* Tier 1 Providers (You will pay the least)	Tier 2 Providers (You will pay more)	Tier 3 Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information* *Services incurred by an Advent Health provider are not eligible for reimbursement (except medically necessary emergency room care)*
If you need mental health, behavioral health, or substance abuse services	Outpatient Facility	30% coinsurance	30% coinsurance	30% coinsurance	The copayment applies per visit and includes lab & x-ray, injections, allergy, and office surgery. The copayment also applies to lab/x-ray and durable medical equipment (except CPAPs), related to the visit but billed by a different provider and incurred within five days of the visit.
	Outpatient Physician	30% coinsurance	30% coinsurance	30% coinsurance	
	Outpatient Office Visits Primary Care Office Visit	$20 copayment per visit; deductible does not apply	$40 copayment per visit; deductible does not apply	30% coinsurance	
	Specialist Office Visit	$40 copayment per visit; deductible does not apply	$80 copayment per visit; deductible does not apply	30% coinsurance	
	Office Visits Primary Care Office Visit	$20 copayment per visit; deductible does not apply	$40 copayment per visit; deductible does not apply	30% coinsurance	
	Specialist Office Visit	$40 copayment per visit; deductible does not apply	$80 copayment per visit; deductible does not apply	30% coinsurance	
	Inpatient Facility	30% coinsurance	30% coinsurance	30% coinsurance	*Pre-certification is required prior to inpatient admissions to avoid a penalty.*
	Inpatient Physician	30% coinsurance	30% coinsurance	30% coinsurance	
If you are pregnant	Office visits	30% coinsurance	30% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). *Pre-certification of maternity admissions that exceed 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery is required to avoid a penalty.*
	Childbirth/delivery professional services	30% coinsurance	30% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	30% coinsurance	30% coinsurance	

* 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 *There is No cost for covered services incurred at an **SDOC Center for Employee Health.** Services incurred due to a **Member Advocacy** recommendation are not subject to deductible.* **Tier 1 Providers (You will pay the least)**	**Tier 2 Providers (You will pay more)**	**Tier 3 Providers (You will pay the most)**	**Limitations, Exceptions, & Other Important Information*** *Services incurred by an Advent Health provider are not eligible for reimbursement (except medically necessary emergency room care)*
If you need help recovering or have other special health needs	Home health care	30% coinsurance	30% coinsurance	30% coinsurance	Coverage is limited to 16 hours daily maximum. *Pre-certification is required prior to home health care to avoid a penalty.*
	Rehabilitation services Inpatient services	30% coinsurance	30% coinsurance	30% coinsurance	*Pre-certification is required prior to inpatient admissions to avoid a penalty.* Inpatient services are limited to 60 days per plan year (combined with skilled nursing facility). Outpatient cardiac rehab is limited to 36 visits per plan year; outpatient physical, speech, occupational, cognitive, & respiratory therapies, and chiropractic care are limited to 60 (combined) visits per plan year. Visit limits do not apply to treatment related to autism spectrum disorders.
	Outpatient/Office services	$40 copayment per visit; deductible does not apply	$80 copayment per visit; deductible does not apply	30% coinsurance	
	Habilitation services	See Rehabilitation services			
	Skilled nursing care	30% coinsurance	30% coinsurance	30% coinsurance	Coverage is limited to 60 days per plan year (combined with inpatient Rehabilitation services). *Pre-certification is required prior to inpatient admissions to avoid a penalty.*
	Durable medical equipment (DME)	30% coinsurance	30% coinsurance	30% coinsurance	*Pre-certification is required prior to DME that exceeds $2,500 (including all Positive Airway Pressure (PAP) machines and humidifiers regardless of cost) to avoid a penalty. Tier 1 & Tier 2 DME (excluding CPAPs), related to an office visit and received within five days of the visit is subject to the Physician's office visit copayment benefit.*
	Hospice services	30% coinsurance	30% coinsurance	30% coinsurance	*Pre-certification is required prior to hospice services to avoid a penalty.*
If your child needs dental or eye care	Children's eye exam	Not Covered			Vision and Dental benefits may be available through a separate plan election.
	Children's glasses	Not Covered			
	Children's dental check-up	Not Covered			

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

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	• Hearing aids	• Private-duty nursing
• Bariatric surgery	• Infertility treatment	• Routine eye care (Adult/Child)
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult/Child)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care		

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: 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 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: EBMS at 1-800-777-3575. 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 888-326-7240.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-326-7240.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 888-326-7240.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-326-7240.

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	**$900**
Primary Care Physician copayment	**$20**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary Care Physician office *(prenatal care)*
Childbirth/Delivery Professional services
Childbirth/Delivery Facility services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$10
Coinsurance	$3,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well- controlled condition)

The plan's overall deductible	**$900**
Specialist Physician copayment	**$40**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist physician office *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Medical supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$2,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,920**

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

The plan's overall deductible	**$900**
Specialist Physician copayment	**$40**
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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

Deductible will not apply when the appropriate provider referral has been obtained.

These coverage examples outline how claims might be considered in general for the medical conditions shown; your actual cost will vary based on specific details of the Plan.

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