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?	**SDOC Center for Employee Health (aka "Health Center"):** no deductible applies; **Tier 1/Tier 2 Evolutions Provider:** $500 per plan participant, $1,000 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. Covered services incurred at the **Health Center,** services for which a **SentryHealth** recommendation is in place, Emergency Room, and **Tier 1/Tier 2 Evolutions Provider:** dependent child PCP preventive care, outpatient/office rehab, urgent care, dependent child PCP office visits, specialty physician office visits (requires referral), and diagnostic labs 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. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**SDOC Center for Employee Health (aka "Health Center"):** a maximum out-of-pocket amount does not apply; **Tier 1/Tier 2 Evolutions Provider:** $4,000 per plan participant, $8,000 per family unit. The out-of-pocket limit starts over each **OCTOBER 1.**	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), non-covered services, 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. See https://etrx.ehsppo.com/ETRXMemberPortal.aspx?EmployerID=32820 or call *SentryHealth* at 844-297-0747, for a list of Tier 1 or Tier 2 *(preferred)* providers.	This plan offers **Health Center services** at No Cost; you will pay discounted expenses if you use an **Evolutions** provider *and a Health Center referral may be required*. You will pay all expenses if you use any other provider (except for Emergency Room/Ambulance services) and you might receive a bill for ancillary provider services (such as anesthesia or 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?	Yes.	This plan will pay some or all of the costs to see a specialist *outside of the Health Center* for covered services, but only if you have a referral before you see the specialist.

⚠ 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 **SentryHealth** recommendation are not subject to deductible.* **Health Center (You will pay nothing)**	**Designated Pediatric PCP** Evolutions Tier 1/Tier 2 Provider **(Dependent children to age 26)**	**Evolutions Tier 1/Tier 2 Provider (Plan Participants age 26 & older)**	Limitations & Other Important Information* *Services incurred other than by a Health Center, Tier 1 or Tier 2 Provider are not eligible for coverage, except medically necessary emergency room care (and unless specified otherwise).*
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	No charge	Not covered	The copayment applies per visit and includes lab & x-ray, injections, allergy, and office surgery. The copayment also includes lab/pathology/x-ray interpretation and DME (except CPAP devices & supplies), related to the visit but billed by a different provider and incurred within five days of the visit. Primary care office visits are no charge for plan participants age 18 & older who utilize a Tier 1/Tier 2 OB/GYN or GYN as their primary care physician.
	Specialist visit	No charge	$30 copayment per visit; deductible does not apply *Health Center referral required. If the referring specialist refers to a different Tier 1 or Tier 2 specialist, the referring specialist must contact SentryHealth for the referral. Pediatrician, OB/GYN or GYN referring to a Specialist; contact SentryHealth for referral.*	$30 copayment per visit; deductible does not apply	
	Preventive care/screening/ immunization	No charge	No charge; services not available at the Health Center or through the pediatric PCP require a referral	No charge; services not available at the Health Center require a referral	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	No charge	20% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	The first colonoscopy and first mammogram each plan year is no charge.
	Diagnostic test - X-ray	No charge	20% coinsurance	20% 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 **SentryHealth** recommendation are not subject to deductible.* **Health Center (You will pay nothing)**	**Designated Pediatric PCP** Evolutions Tier 1/Tier 2 Provider **(Dependent children to age 26)**	**Evolutions Tier 1/Tier 2 Provider (Plan Participants age 26 & older)**	**Limitations & Other Important Information*** *Services incurred other than by a Health Center, Tier 1 or Tier 2 Provider are not eligible for coverage, except medically necessary emergency room care (and unless specified otherwise).*
	Imaging (CT/PET scans, MRIs)	Not available	20% coinsurance	20% coinsurance	Imaging services may be available at no charge: *Green Imaging, LLC;* 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.*
If you need drugs to treat your illness or condition. For more information contact https://www.ventegra.com/	Generic drugs	Prescription Drugs or Products must be obtained through **Prescriptions Unlimited Pharmacy, Publix Pharmacy, or Walmart Pharmacy** to be eligible for reimbursement $0 copayment per prescription (30, 60, 90-day supply) *(Generic drugs may also be obtained through the Health Center at $0 copayment per prescription)*			Prescription drugs or products obtained other than at a Prescriptions Unlimited Pharmacy, Publix Pharmacy, or Walmart Pharmacy are not eligible *(unless Medically Necessary due to an emergency)*. Retail drugs are available up to a 90-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 charge through the ElectRx International Mail Order Program. Contact https://www.electrx.com/ for more information.
	Formulary brand drugs	$45 copayment per prescription (30-day supply) $90 copayment per prescription (60-day supply) $135 copayment per prescription (90-day supply)			
	Non-formulary brand drugs	50% copayment ($150 max) per prescription (30-day supply) 50% copayment ($300 max) per prescription (60-day supply) 50% copayment ($450 max) per prescription (90-day supply)			
	Specialty drugs	$75 copayment per prescription (30-day supply only)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not available at the Health Center	20% coinsurance	20% coinsurance	*Pre-certification is required prior to outpatient surgery to avoid a penalty.*
	Physician/surgeon fees		20% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	Not available at the Health Center	$400 copayment per visit; deductible does not apply *(copayment waived if admitted)*.		*Pre-certification subsequent to an admission from the emergency room is required to avoid a penalty.* Non-Tier 1/Tier 2 provider expenses are reimbursed subject to the allowable claim limit.
	Emergency medical transportation	Not available at the Health Center	20% coinsurance		Non-Tier 1/Tier 2 provider expenses are reimbursed subject to the allowable claim limit.

* 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 **SentryHealth** recommendation are not subject to deductible.* **Health Center (You will pay nothing)**	**Designated Pediatric PCP** Evolutions Tier 1/Tier 2 Provider **(Dependent children to age 26)**	**Evolutions Tier 1/Tier 2 Provider (Plan Participants age 26 & older)**	**Limitations & Other Important Information*** *Services incurred other than by a Health Center, Tier 1 or Tier 2 Provider are not eligible for coverage, except medically necessary emergency room care (and unless specified otherwise).*
	Urgent care	Not available at the Health Center	$45 copayment per visit; deductible does not apply	$45 copayment per visit; deductible does not apply	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)	Not available at the Health Center	20% coinsurance	20% coinsurance	*Pre-certification is required prior to inpatient admissions to avoid a penalty.*
	Physician/surgeon fees		20% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient Facility	Not available at the Health Center	20% coinsurance	20% coinsurance	The copayment applies per visit and includes lab & x-ray, injections, allergy, and office surgery. The copayment also includes lab/pathology/x-ray interpretation and DME (except CPAP devices & supplies), related to the visit but billed by a different provider and incurred within five days of the visit. Primary care office visits are no charge for plan participants age 18 & older who utilize a Tier 1/Tier 2 OB/GYN or GYN as their primary care physician.
	Outpatient Physician		20% coinsurance	20% coinsurance	
	Office Visits Primary Care Office Visit	No charge	No charge	Not covered	
	Specialist Office Visit	No charge	$30 copayment per visit; deductible does not apply	$30 copayment per visit; deductible does not apply	
	Inpatient Facility	Not available at the Health Center	20% coinsurance	20% coinsurance	*Pre-certification is required prior to inpatient admissions to avoid a penalty.*
	Inpatient Physician		20% coinsurance	20% coinsurance	
If you are pregnant	Office visits – Initial Primary Care Physician	No charge	No charge	OB/GYN or GYN: $30 copayment per visit; deductible does not apply	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). *If the referring specialist refers to a different Tier 1 or Tier 2 specialist, the referring specialist must contact SentryHealth for the referral. OB/GYN or GYN referring to a Specialist; contact SentryHealth for referral.*
	Specialty Physician	No charge	$30 copayment per visit; deductible does not apply	$30 copayment per visit; deductible does not apply	
			Health Center referral required.		

* 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 **SentryHealth** recommendation are not subject to deductible.* **Health Center (You will pay nothing)**	**Designated Pediatric PCP** Evolutions Tier 1/Tier 2 Provider **(Dependent children to age 26)**	**Evolutions Tier 1/Tier 2 Provider (Plan Participants age 26 & older)**	**Limitations & Other Important Information*** *Services incurred other than by a Health Center, Tier 1 or Tier 2 Provider are not eligible for coverage, except medically necessary emergency room care (and unless specified otherwise).*
If you are pregnant	Childbirth/delivery professional	Not available at the Health Center	20% coinsurance	20% coinsurance	*Pre-certification required for maternity admissions exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean delivery to avoid a penalty.*
	Childbirth/delivery facility		20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not available at the Health Center	20% coinsurance	20% 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	Not available at the Health Center	20% coinsurance	20% coinsurance	*Pre-certification required prior to admission to avoid a penalty.* Inpatient limited to 60 days/plan year (combined with skilled nursing). Outpatient cardiac rehab limited to 36 visits/plan year; outpatient physical/speech/cognitive/respiratory/ occupational therapies, and chiropractic care are limited to 60 (combined) visits/plan year. Visit limits do not apply to treatment related to autism spectrum disorders.
	Outpatient/Office services	Not available at the Health Center	$30 copayment per visit; deductible does not apply	$30 copayment per visit; deductible does not apply	
	Habilitation services	See Rehabilitation services			
	Skilled nursing care	Not available at the Health Center	20% coinsurance	20% 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)	No charge	20% coinsurance	20% coinsurance	*Pre-certification is required for Tier 1/Tier 2 providers prior to DME that exceeds $2,500 (including all Positive Airway Pressure (PAP) machines and humidifiers regardless of cost) to avoid a penalty. 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	Not available at the Health Center	20% coinsurance	20% coinsurance	*Pre-certification is required prior to hospice services to avoid a penalty.*

* 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 **SentryHealth** recommendation are not subject to deductible.*			Limitations & Other Important Information* *Services incurred other than by a Health Center, Tier 1 or Tier 2 Provider are not eligible for coverage, except medically necessary emergency room care (and unless specified otherwise).*
		Health Center (You will pay nothing)	**Designated Pediatric PCP** Evolutions Tier 1/Tier 2 Provider **(Dependent children to age 26)**	**Evolutions Tier 1/Tier 2 Provider (Plan Participants age 26 & older)**	
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			

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- 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.)

- Chiropractic care

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

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	**$500**
Primary Care Physician copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary Care Physician office (OB/GYN-GYN) *(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	$500
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,960**

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

The plan's overall deductible	**$500**
Specialist Physician copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$2,600
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,640**

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

The plan's overall deductible	**$500**
Specialist Physician copayment	**$30**
Hospital (ER facility) copayment	**$400**
Other coinsurance	**20%**

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	$500
Copayments	$610
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,270**

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.