




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:
<p>What is the overall deductible?</p>	<p>Tier 1 Providers: \$600 per <u>plan</u> participant, \$1,200 per family unit. Tier 2 Providers: \$950 per <u>plan</u> participant, \$1,900 per family unit. Tier 3 Providers: \$950 per <u>plan</u> participant, \$1,900 per family unit. <u>Deductible</u> starts over each OCTOBER 1.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. <u>Preventive care</u>, outpatient/office rehab, <u>urgent care</u>, outpatient office visits and office visits, and diagnostic lab are covered before you meet your <u>deductible</u>. Also, <i>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 <u>deductible</u>.</i></p>	<p>This <u>plan</u> covers some items and <u>services</u> even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$75 per <u>plan</u> participant for <u>prescription drugs</u>. <i>Does not apply to generic drugs or <u>preferred pharmacy brand drugs</u>.</i></p>	<p>Yes: You must pay all of the costs for these <u>services</u> up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these <u>services</u>.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Tier 1 Providers including <u>preferred pharmacy</u> expenses: \$4,000 per <u>plan</u> participant, \$8,000 per family unit. Tier 2 Providers including non-<u>preferred pharmacy</u> expenses: \$6,700 per <u>plan</u> participant, \$12,400 per family unit. Tier 3 Providers: \$6,700 per <u>plan</u> participant, \$12,400 per family unit.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered <u>services</u>. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Pre-certification penalties, <u>prescription drug DAW</u> penalties & discounts/coupons, <u>premiums</u>, <u>balance-billing</u> charges (unless <u>balance-billing</u> is prohibited), and health care this <u>plan</u> doesn't cover. The <u>out-of-pocket limit</u> starts over each OCTOBER 1.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See https://etrx.ehsppo.com/ETRXMemberPortal.aspx?EmployerID=32820 or call <i>Member Advocacy</i> at 844-297-0747, for a list of Tier 1 or Tier 2 (<u>preferred</u>) <u>providers</u>.</p>	<p>This <u>plan</u> offers <u>preferred provider</u> opportunities. You will pay less if you use a Tier 1 or Tier 2 (<u>preferred</u>) <u>provider</u>. You will pay more if you use a Tier 3 (non-<u>preferred</u>) <u>provider</u>, and you might receive a bill from a Tier 3 <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your Tier 1 or Tier 2 (<u>preferred</u>) <u>provider</u> might use a Tier 3 (non-<u>preferred</u>) <u>provider</u> for some <u>services</u> (such as lab work). Check with your <u>provider</u> before you get <u>services</u>.</p>

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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* 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$15 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$25 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$30 <u>copayment</u> per visit; <u>deductible</u> does not apply	The <u>copayment</u> applies per visit and includes lab & x-ray, injections, allergy, and office surgery. The <u>copayment</u> also applies to lab/x-ray and <u>durable medical equipment</u> (except CPAPs), related to the visit but billed by a different provider and incurred within five days of the visit. You may have to pay for <u>services</u> that aren't <u>preventive</u> . Ask your <u>provider</u> if the <u>services</u> needed are <u>preventive</u> , then check what your <u>plan</u> will pay.
	<u>Specialist</u> visit	\$40 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$50 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$60 <u>copayment</u> per visit; <u>deductible</u> does not apply	
	<u>Preventive care/screening/immunization</u>	No cost	No cost	No cost	
If you have a test	<u>Diagnostic test</u> - Lab	\$5 <u>copayment</u> per visit; <u>deductible</u> does not apply	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	The first colonoscopy and the first mammogram each <u>plan</u> year is available at No cost. Imaging services may be available at no cost through <i>Green Imaging, LLC</i> ; contact www.greenimaging.net . <i>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.</i>
	<u>Diagnostic test</u> - X-ray	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	

* 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 <i>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.</i>			Limitations, Exceptions, & Other Important Information* <i>Services incurred by an Advent Health provider are not eligible for reimbursement (except medically necessary emergency room care)</i>
		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 need drugs to treat your illness or condition. For more information contact https://www.ventegra.com/		Preferred Pharmacy		Non-Preferred Pharmacy	The <u>prescription drug deductible</u> applies to non-preferred pharmacy brand drugs*. <u>Copayments</u> apply <i>per prescription</i> . Retail drugs are available up to a 91-day supply per prescription. <u>Specialty drugs</u> 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. <i>For a current list of <u>preferred</u> and <u>non-preferred</u> pharmacies contact Ventegra at: https://www.ventegra.com/. <u>Prescription drugs</u> obtained through a Pharmacy that is not part of the <u>Ventegra Nationwide Network</u> are not eligible for reimbursement.</i>
	Generic drugs				
	30-day supply	\$5 <u>copayment</u>		\$10 <u>copayment</u>	
	31 to 60-day supply	\$10 <u>copayment</u>		\$20 <u>copayment</u>	
	61 to 91-day supply	\$15 <u>copayment</u>		\$30 <u>copayment</u>	
	Formulary brand drugs				
30-day supply	\$40 <u>copayment</u>		*20% <u>copayment</u> (\$50 max)		
31 to 60-day supply	\$80 <u>copayment</u>		*20% <u>copayment</u> (\$100 max)		
61 to 91-day supply	\$120 <u>copayment</u>		*20% <u>copayment</u> (\$150 max)		
Non-formulary brand drugs					
30-day supply	50% <u>copayment</u> (\$125 max)		*50% <u>copayment</u> (\$150 max)		
31 to 60-day supply	50% <u>copayment</u> (\$250 max)		*50% <u>copayment</u> (\$300 max)		
61 to 91-day supply	50% <u>copayment</u> (\$375 max)		*50% <u>copayment</u> (\$450 max)		
Specialty drugs	50% <u>copayment</u> (\$200 max)		Not Covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	<i>Pre-certification is required prior to outpatient surgery to avoid a penalty.</i>
	Physician/surgeon fees	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	25% <u>coinsurance</u> <i>(subject to Tier 1 deductible and out-of-pocket limit)</i>			<i>Pre-certification subsequent to an admission from the emergency room is required to avoid a penalty.</i>
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u> <i>(subject to Tier 1 deductible and out-of-pocket limit)</i>			None.
	<u>Urgent care</u>	\$45 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$45 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$100 <u>copayment</u> per visit; <u>deductible</u> does not apply	The <u>copayment</u> 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)	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	<i>Pre-certification is required prior to inpatient admissions to avoid a penalty.</i>
	Physician/surgeon fees	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	

* 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 <i>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.</i>			Limitations, Exceptions, & Other Important Information* <i>Services incurred by an Advent Health provider are not eligible for reimbursement (except medically necessary emergency room care)</i>
		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 need mental health, behavioral health, or substance abuse services	Outpatient Facility	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	The <u>copayment</u> applies per visit and includes lab & x-ray, injections, allergy, and office surgery. The <u>copayment</u> also applies to lab/x-ray and <u>durable medical equipment</u> (except CPAPs), related to the visit but billed by a different provider and incurred within five days of the visit.
	Outpatient Physician	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	
	Outpatient Office Visits				
	Primary Care Office Visit	\$15 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$25 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$30 <u>copayment</u> per visit; <u>deductible</u> does not apply	
	Specialist Office Visit	\$40 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$50 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$60 <u>copayment</u> per visit; <u>deductible</u> does not apply	
	Office Visits				
	Primary Care Office Visit	\$15 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$25 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$30 <u>copayment</u> per visit; <u>deductible</u> does not apply	
Specialist Office Visit	\$40 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$50 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$60 <u>copayment</u> per visit; <u>deductible</u> does not apply		
Inpatient Facility	Inpatient Facility	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	<i>Pre-certification is required prior to inpatient admissions to avoid a penalty.</i>
	Inpatient Physician	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	
If you are pregnant	Office visits	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Cost sharing does not apply to certain <u>preventive services</u> . Depending on the type of <u>services</u> , <u>coinsurance</u> may apply. Maternity care may include tests and <u>services</u> described elsewhere in the SBC (e.g., ultrasound). <i>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.</i>
	Childbirth/delivery professional services	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	

* 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 <i>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.</i>			Limitations, Exceptions, & Other Important Information* <i>Services incurred by an Advent Health provider are not eligible for reimbursement (except medically necessary emergency room care)</i>
		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 need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Coverage is limited to 16 hours daily maximum. <u>Pre-certification is required prior to home health care to avoid a penalty.</u>
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	<u>Pre-certification is required prior to inpatient admissions to avoid a penalty.</u> Inpatient services are limited to 60 days per <u>plan</u> year (combined with skilled nursing facility). Outpatient cardiac rehab is limited to 36 visits per <u>plan</u> year; outpatient physical, speech, occupational, cognitive, & respiratory therapies, and chiropractic care are limited to 60 (combined) visits per <u>plan</u> year. Visit limits do not apply to treatment related to autism spectrum disorders.
	Inpatient services				
	Outpatient/Office services	\$40 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$50 <u>copayment</u> per visit; <u>deductible</u> does not apply	\$60 <u>copayment</u> per visit; <u>deductible</u> does not apply	
	<u>Habilitation services</u>	See <u>Rehabilitation services</u>			
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Coverage is limited to 60 days per <u>plan</u> year (combined with inpatient <u>Rehabilitation services</u>). <u>Pre-certification is required prior to inpatient admissions to avoid a penalty.</u>
	<u>Durable medical equipment (DME)</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	<u>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.</u> DME (excluding CPAPs), related to an office visit and received within five days of the visit is subject to the Physician's office visit <u>copayment</u> benefit.
<u>Hospice services</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	<u>Pre-certification is required prior to hospice services to avoid a penalty.</u>	
If your child needs dental or eye care	Children's eye exam	Not Covered			Vision and Dental benefits may be available through a separate <u>plan</u> 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
- 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

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, kwijigo holne' 888-326-7240.

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

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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 \$600
- Primary Care Physician copayment \$15
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$600
- Specialist Physician copayment \$40
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture

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

- The plan's overall deductible \$600
- Specialist Physician copayment \$40
- 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200

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.