Public Education Health Trust: Plan B

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 **1-866-247-1443** 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?	$250 per covered person or $750 per family unit. Each **JANUARY** a new deductible amount is required.	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. Air ambulance, BridgeHealth or *mi*Choice Surgery Benefit, Teladoc physician consultations, and the following preferred provider services: prescription drug coverage, and preventive care, are covered before you meet your deductible. Copayments do not apply to the 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. $500 per inpatient admission, limited to two deductibles per person per calendar year; and $500 per non-medical emergency room visit. There are no other specific deductibles.	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?	**Medical coinsurance maximum out-of-pocket:** Preferred Providers: $2,000 per covered person / $6,000 per family unit. Non-Preferred Providers: Unlimited. **Super global maximum out-of-pocket** (is the most a member will pay in a calendar year for deductibles, copayments and coinsurance): Preferred Providers: $7,350 per covered person / $14,700 per family unit; Non-Preferred Providers: Unlimited.	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 and prescription drug copayments are not included in the medical coinsurance maximum out-of-pocket limit. Non-preferred provider or facility penalty, Vision Service Plan benefits, prescription drug discounts or coupons, any difference between the private and semi-private room rate when a semi-private room is available, premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover are not included in the medical coinsurance maximum out-of-pocket limit or super global maximum out-of-pocket limit.	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. Refer to your EBMS/Public Education Health Trust identification card, or login to www.ebms.com or call 1-866-247-1443 for a list of network providers.	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
		Preferred Provider (You will pay the least)	Non-Preferred 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	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	Coverage limited to 20 visits/calendar year for massage therapy. Coverage limited to 20 visits/calendar year for spinal manipulation/ chiropractic services.
	Specialist visit	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	
	Preventive care/screening/ immunization	No charge	0% coinsurance up to the allowed amount; 125% of Medicare	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 for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	Pre-notification is recommended.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com/myOptumRx or call	Generic drugs	$12 copayment/ prescription (retail) $24 copayment/ prescription (mail order)		Coverage is limited to 30-day supply per prescription retail or 90-day supply per prescription mail order. At select pharmacies a 90-day supply option may be available at the same cost as mail order, including compounds. If a covered person requests a preferred name drug when a generic equivalent is available, they are responsible for the preferred name drug coinsurance plus the difference in cost between the preferred name drug and the generic drug.
	Compound drugs	$12 copayment/ prescription (retail)		
	Preferred brand name drugs	$25 copayment/ prescription (retail) $50 copayment/ prescription (mail order)		
	Non-preferred brand name drugs	$50 copayment/ prescription (retail) $100 copayment/ prescription (mail order)		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
1-855-395-2022.	Specialty drugs - Value specialty drugs - Formulary specialty - Non-formulary specialty	50% coinsurance up to $100 50% coinsurance up to $400 50% coinsurance up to $600	Not Covered	Deductible does not apply. Specialty drugs limited to a 30-day supply/ prescription & **requires purchase through the specialty pharmacy program**. **Non-preferred specialty pharmacy is not covered.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	Pre-notification is recommended.
	Physician/surgeon fees	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	None
If you need immediate medical attention	Emergency room care - Medical Emergency - Non-medical Emergency	20% coinsurance		Coverage limited to services from the nearest hospital where professional and necessary treatment can be provided due to a Medical Emergency. The emergency room deductible is waived for medical emergency, accidental injury, or if admitted as an inpatient.
		20% coinsurance after overall deductible and $500/visit emergency room deductible	0% coinsurance up to the allowed amount; 125% of Medicare after overall deductible and $500/visit emergency room deductible	
	Emergency medical transportation - Ground ambulance - Air ambulance	20% coinsurance		Coverage limited to services to the nearest hospital or skilled nursing facility where professional and necessary treatment can be provided as medically necessary. Pre-notification is strongly recommended for air ambulance services. **Please Call 1-800-228-9118.**
		0% coinsurance up to the allowed amount; 125% of Medicare; deductible does not apply		
	Urgent care	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after overall deductible and $500/ admission inpatient deductible	0% coinsurance up to the allowed amount; 125% of Medicare after overall deductible and $500/ admission inpatient deductible	Pre-notification is recommended. The inpatient deductible will only be applied twice/calendar year per covered person. Coverage limited to the semi-private room rate.
	Physician/surgeon fees	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	None
	Inpatient services	20% coinsurance after overall deductible and $500/ admission inpatient deductible	0% coinsurance up to the allowed amount; 125% of Medicare after overall deductible and $500/ admission inpatient deductible	Pre-notification is recommended. The inpatient deductible will only be applied twice/calendar year per covered person. Coverage limited to the semi-private room rate.
If you are pregnant	Office visits	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	Maternity benefits only apply to covered employee or covered spouse. 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).
	Childbirth/delivery professional services	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	
	Childbirth/delivery facility services	20% coinsurance after overall deductible and $500/ admission inpatient deductible	0% coinsurance up to the allowed amount; 125% of Medicare after overall deductible and $500/ admission inpatient deductible	The inpatient deductible will only be applied twice/calendar year covered per person. Coverage limited to the semi-private room rate.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	None
	Rehabilitation services	Outpatient: 20% coinsurance Inpatient: 20% coinsurance after overall deductible and $500/ admission inpatient deductible	Outpatient: 0% coinsurance up to the allowed amount; 125% of Medicare Inpatient: 0% coinsurance up to the allowed amount; 125% of Medicare after overall deductible and $500/ admission inpatient deductible	Pre-notification is recommended. The inpatient deductible will only be applied twice/calendar year per covered person. **Inpatient** is limited to 180 combined days/calendar year for Inpatient Rehabilitation Therapy and Skilled Nursing Facility and subject to the semi-private room rate. **Outpatient** includes speech, physical, and occupational therapies. Physical and occupational therapies are limited to 20 visits per therapy/calendar year.
	Habilitation services			
	Skilled nursing care	20% coinsurance after overall deductible and $500/ admission inpatient deductible	0% coinsurance up to the allowed amount; 125% of Medicare after overall deductible and $500/ admission inpatient deductible	Pre-notification is recommended. The inpatient deductible will only be applied twice/calendar year per covered person. Coverage limited to 180 combined days/calendar year for Inpatient Rehabilitation Therapy and Skilled Nursing Facility and subject to the semi-private room rate.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance		Pre-notification is recommended for DME expenses over $2,000.
	Hospice services	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	Pre-notification is recommended.
If your child needs dental or eye care	Children's eye exam	$25 copayment	Up to $50	PEHT has contracted with Vision Service Plan (VSP) to provide vision care services. Coverage limited to one exam/calendar year.
	Children's glasses	$25 copayment	Up to $70 for frame Up to $50 for single vision lenses Up to $75 for bifocal lenses Up to $75 for progressive lenses Up to $100 for trifocal lenses	Coverage limited to one pair of lenses/calendar year and one frame every other calendar year.
	Children's dental check-up	Not covered		Dental benefits may be available as a separate election.

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
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Routine eye care (Adult) through VSP
- Routine Foot 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 at1-800-777-3575** 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 **1-866-247-1443**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog **1-866-247-1443**.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码 1-866-247-1443**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-247-1443**.

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	**$250**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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*	$750
Copayments	$48
Coinsurance	$2,520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,378**

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

The plan's overall deductible	**$250**
Primary care physician coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$250
Copayments	$697
Coinsurance	$585
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,592**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$750
Copayments	$0
Coinsurance	$230
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$980**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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