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?	$100 per covered person or $300 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, Transcarent Surgery Benefit or *mi*Choice Surgery Benefit, Sword Health (virtual physical care), Coronary Artery Bypass Graft benefit through Providence Alaska Medical Center and NorthStarr Cardiothoracic Surgery, LLC, Teladoc physician consultations (including Primary360), 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Preferred Providers: $1,000 per covered person / $3,000 per family unit; Non-Preferred Providers: Unlimited. Prescription Drugs: $3,000 per covered person / $6,000 per family unit	The out-of-pocket limit is the most you could pay in a calendar 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/coinsurance, prescription drug maximum out-of-pocket amount are not included in the medical maximum out-of-pocket limit. Non-preferred provider or facility penalty, Vision Service Plan benefits, prescription drug discounts or coupons, premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover are not included in the medical 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	Limited to 20 visits/calendar year for massage therapy. 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 1-855-395-2022.	Generic drugs or Compound drugs	25% ($10 min/$25 max) copayment/coinsurance per prescription (34-day retail supply) 25% ($20 min/$50 max) copayment/coinsurance per prescription 35 to 90-day retail or mail order supply)		Deductible does not apply. If a covered person requests a brand name drug when a generic equivalent is available, they are responsible for the brand name drug copayment/coinsurance plus the difference in cost between the brand name drug and the generic drug. Prescription Drug copayment/coinsurance applies towards the prescription drug maximum out-of-pocket amount.
	Preferred brand name drugs	25% ($35 min/$55 max) copayment/coinsurance per prescription (retail up to 34-day supply) 25% ($70 min/$100 max) copayment/coinsurance per prescription (retail or mail order 35 to 90-day supply)		
	Non-preferred brand name drugs	25% ($55 min/$95 max) copayment/coinsurance per prescription (retail up to 34-day supply) 25% ($110 min/$190 max) copayment/coinsurance per prescription (retail or mail order 35 to 90-day supply)		
	Specialty drugs - **Value (Tier 1)** - **Formulary (Tier 2)** - **Non-formulary (Tier 3)**	25% copayment/coinsurance up to $50 per prescription 25% copayment/coinsurance up to $200 per prescription 50% copayment/coinsurance up to $600 per prescription		Deductible does not apply. Specialty drugs are limited to a 30-day supply per prescription. Prescription Drug copayment/coinsurance applies towards the prescription drug maximum out-of-pocket amount.

* 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		Limitations, Exceptions, & Other Important Information*
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
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	20% coinsurance		Limited to services from the nearest hospital where professional and necessary treatment can be provided due to a Medical Emergency.
	Emergency medical transportation - **Ground ambulance** - **Air ambulance**	20% coinsurance 0% coinsurance up to the allowed amount; 125% of Medicare; deductible does not apply		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.**
	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	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 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	0% coinsurance up to the allowed amount; 125% of Medicare	Pre-notification is recommended.
If you are pregnant	Office visits	20% coinsurance	0% coinsurance up to the allowed amount; 125% of Medicare	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	0% coinsurance up to the allowed amount; 125% of Medicare	None

* 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		Limitations, Exceptions, & Other Important Information*
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
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	Pre-notification is recommended.
	Rehabilitation services	Outpatient: 20% coinsurance	Outpatient: 0% coinsurance up to the allowed amount; 125% of Medicare	Pre-notification is recommended. **Inpatient** is limited to 180 combined days/calendar year for Inpatient Rehabilitation Therapy and Skilled Nursing Facility. **Outpatient** includes speech, physical, and occupational therapies. Physical and occupational therapies are limited to 20 visits per therapy/calendar year.
	Habilitation services	Inpatient: 20% coinsurance	Inpatient: 0% coinsurance up to the allowed amount; 125% of Medicare	
	Skilled nursing care	20% coinsurance after overall deductible	0% coinsurance up to the allowed amount; 125% of Medicare	Pre-notification is recommended. Limited to 180 combined days/calendar year for Inpatient Rehabilitation Therapy and Skilled Nursing Facility.
	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	No Charge	Up to $50	PEHT has contracted with Vision Service Plan (VSP) to provide vision care services; vision expenses do not apply to the medical deductible or maximum out-of-pocket amounts. Limited to one exam/calendar year and to one pair of lenses/calendar year and one frame every other calendar year.
	Children's glasses	$25 copayment	Up to $70 for frame Up to $50 for single vision lenses Up to $75 for lined bifocal lenses Up to $75 for progressive lenses Up to $100 for lined trifocal lenses	
	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

* 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: contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 **1-866-247-1443**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **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.

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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** **$100**
- **Primary care physician** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

Primary care physician office visits *(prenatal care)*
Childbirth/Delivery Professional services
Childbirth/Delivery Facility services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,570**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$100**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:

Specialist office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$100**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$610**

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