




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?	\$1,500 per covered person or \$3,000 per family unit. Each JANUARY a new <u>deductible</u> amount is required.	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> .
Are there services covered before you meet your deductible?	Yes. Air ambulance, BridgeHealth or <i>miChoice</i> 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, and the following preferred provider services: first six office visits for primary care and mental health substance abuse physician services, <u>prescription drug coverage</u> , and <u>preventive care</u> , are covered before you meet your deductible. <u>Copayments</u> do not apply to the <u>deductible</u> .	This <u>plan</u> covers some items and services 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/ .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific <u>services</u> .
What is the out-of-pocket limit for this plan?	Preferred Providers: \$3,000 per covered person or \$6,000 per family unit; Non-Preferred Providers: Unlimited Prescription Drugs: \$3,000 per covered person / \$6,000 per family unit	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. 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>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Deductibles, copayments, and prescription drug copayments/coinsurance, prescription drug maximum out-of-pocket amount</u> are not included in the medical <u>maximum out-of-pocket limit</u>. Non-preferred provider or facility penalty, Vision Service Plan benefits, <u>prescription drug discounts or coupons</u>, any difference between the private and semi-private room rate when a semi-private room is available, <u>premiums, balance-billing charges</u> (unless balanced billing is prohibited), and health care this <u>plan</u> doesn't cover are not included in the medical maximum <u>out-of-pocket limit</u>.</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 <u>network provider</u>?</p>	<p>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 <u>network providers</u>.</p>	<p>This <u>plan</u> uses a provider <u>network</u>. You will pay less if you use a <u>provider in the plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <u>referral to see a specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

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

 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	\$25 <u>copayment</u> /visit, deductible does not apply; or 20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	For <u>preferred providers</u> , the first six (combined) office visits (other than outpatient mental disorder or substance abuse treatment), including acupuncture, chiropractor and massage therapy /calendar year are subject to a \$25 office visit <u>copayment</u> ; thereafter, covered charges are subject to <u>deductible</u> and <u>coinsurance</u> . Limited to 20 visits/calendar year for massage therapy. Limited to 20 visits/calendar year for spinal manipulation/chiropractic services.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	
	<u>Preventive care/screening/immunization</u>	No charge	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	None
	<u>Imaging</u> (CT/PET scans, MRIs)	20% <u>coinsurance</u>	0% <u>coinsurance</u> 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 or call 1-855-395-2022.	Generic drugs or Compound drugs	30% (\$15 min/\$35 max) <u>copayment/coinsurance</u> per prescription (34-day retail supply)	30% (\$30 min/\$70 max) <u>copayment/coinsurance</u> 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 <u>copayment/coinsurance plus the difference in cost between the brand name drug and the generic drug</u> . <u>Prescription Drug copayment/coinsurance</u> applies towards the <u>prescription drug</u> maximum out-of-pocket amount.
		Preferred brand name drugs		
	Non-preferred brand name drugs	30% (\$55 min/\$100 max) <u>copayment/coinsurance</u> per prescription (34-day retail supply) 30% (\$110 min/\$200 max) <u>copayment/coinsurance</u> per prescription (35 to 90-day retail or mail order supply)		
	<u>Specialty drugs</u>	50% <u>copayment/coinsurance</u> up to \$100 per prescription	Deductible does not apply. <u>Specialty drugs</u> are limited to a 30-day supply per prescription. <u>Prescription Drug copayment/coinsurance</u> applies towards the <u>prescription drug</u> maximum out-of-pocket amount.	
	Value (Tier 1)	50% <u>copayment/coinsurance</u> up to \$400 per prescription		
Formulary (Tier 2)	50% <u>copayment/coinsurance</u> up to \$600 per prescription			
Non-formulary (Tier 3)				

* 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% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended.
	Physician/surgeon fees	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>		Limited to services from the nearest hospital where professional and necessary treatment can be provided due to a Medical Emergency.
	<u>Emergency medical transportation</u> Ground ambulance Air ambulance	20% <u>coinsurance</u> 0% <u>coinsurance</u> 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.
	<u>Urgent care</u>	<u>Payable per normal plan provisions</u>	<u>Payable per normal plan provisions</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended. Limited to the semi-private room rate.
	Physician/surgeon fees	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copayment</u> /visit, deductible does not apply; or 20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	For <u>preferred providers</u> , the first six (combined) office visits (mental disorder or substance abuse treatment)/calendar year are subject to a \$25 office visit <u>copayment</u> ; thereafter, covered charges are subject to <u>deductible</u> and <u>coinsurance</u> .
	Inpatient services	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended.

* 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 are pregnant	Office visits	\$25 <u>copayment</u> /visit, deductible does not apply; or 20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	For <u>preferred providers</u> , the first six (combined) office visits (other than outpatient mental disorder or substance abuse treatment)/calendar year are subject to a \$25 office visit <u>copayment</u> ; thereafter, covered charges are subject to <u>deductible</u> and <u>coinsurance</u> . <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended.
	<u>Rehabilitation services</u>	<u>Outpatient:</u> \$25 <u>copayment</u> /visit, deductible does not apply; or 20% <u>coinsurance</u>	<u>Outpatient:</u> 0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	For <u>preferred providers</u> , the first six (combined) office visits (other than outpatient mental disorder or substance abuse treatment)/calendar year are subject to a \$25 office visit <u>copayment</u> ; thereafter, covered charges are subject to <u>deductible</u> and <u>coinsurance</u> . Pre-notification is recommended. 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.
	<u>Habilitation services</u>	<u>Inpatient:</u> 20% <u>coinsurance</u>	<u>Inpatient:</u> 0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	0% <u>coinsurance</u> 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 and subject to the semi-private room rate.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>		Pre-notification is recommended for DME expenses over \$2,000.
	<u>Hospice services</u>	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended.

* 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 your child needs dental or eye care	Children's eye exam	\$25 <u>copayment</u>	Up to \$50	PEHT has contracted with Vision Service Plan (VSP) to provide vision care services; vision expenses do not apply to the <u>medical deductible</u> or <u>maximum out-of-pocket amounts</u> . 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 <u>copayment</u>	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		

* 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.)

- 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. 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, kwijigo 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 \$1,500
- Primary care physician \$25
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,670

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1,500
- Specialist copayment or 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,200
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

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

- The plan's overall deductible \$1,500
- Specialist copayment or 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800