



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 <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, Transcarent Surgery Benefit 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 (including Primary360), and the following preferred provider services: <u>prescription drug coverage</u> , and <u>preventive care</u> , are covered before you meet your <u>deductible</u> . <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: \$2,000 per covered person / \$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.
What is not included in the out-of-pocket limit?	<u>Deductibles</u> and <u>prescription drug copayments/coinsurance</u> , <u>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> , <u>premiums</u> , <u>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 <u>maximum out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <u>network provider</u>?	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> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>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</u> charge 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.
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*
		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% <u>coinsurance</u>	0% <u>coinsurance</u> 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.
	<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	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
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
	Imaging (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 <u>prescription drug coverage</u> is available at www.Rightway.com or call (833) 419-6546	Generic drugs or Compound drugs	25% (\$10 min/\$25 max) <u>copayment/coinsurance</u> per prescription (34-day retail supply) 25% (\$20 min/\$50 max) <u>copayment/coinsurance</u> per prescription (35 to 90-day retail or mail order supply)		<u>Deductible</u> 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</u> plus the difference in cost between the brand name drug and the generic drug. <u>Prescription Drug copayment/coinsurance</u> applies towards the <u>prescription drug</u> maximum out-of-pocket amount.
	Preferred brand name drugs	25% (\$35 min/\$55 max) <u>copayment/coinsurance</u> per prescription (34-day retail supply) 25% (\$70 min/\$110 max) <u>copayment/coinsurance</u> per prescription (35 to 90-day retail or mail order supply)		
	Non-preferred brand name drugs	25% (\$55 min/\$95 max) <u>copayment/coinsurance</u> per prescription (34-day retail supply) 25% (\$110 min/\$190 max) <u>copayment/coinsurance</u> per prescription (35 to 90-day retail or mail order supply)		
	<u>Specialty drugs</u> - Value (Tier 1) - Formulary (Tier 2) - Non-formulary (Tier 3)	25% <u>copayment/coinsurance</u> up to \$50 per prescription 25% <u>copayment/coinsurance</u> up to \$200 per prescription 50% <u>copayment/coinsurance</u> up to \$600 per prescription		<u>Deductible</u> 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.

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

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; <u>deductible</u> does not apply		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.
	<u>Urgent care</u>	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	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.
	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	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	None
	Inpatient services	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended.

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

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	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	<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	None
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> 20% <u>coinsurance</u>	<u>Outpatient:</u> 0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare <u>Inpatient:</u> 0% <u>coinsurance</u> 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. Speech Therapy is limited to 52 visits per Calendar Year (with additional visits allowed when deemed Medically Necessary).
	<u>Habilitation services</u>	<u>Inpatient:</u> 20% <u>coinsurance</u>		
	<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.
	<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.

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	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 <u>deductible</u> or <u>maximum out-of-pocket</u> 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 <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		Dental benefits may be available as a separate election.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• 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 <u>plan</u> 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	\$250
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$10
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,720

Managing Joe's Type 2 Diabetes

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

■ 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 (*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:

Cost Sharing	
Deductibles	\$250
Copayments	\$400
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$970

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$10
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$760