

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for Employee + Family | Plan Type: Dental



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.AlaskaCare.gov or by calling 1-800-821-2251.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<p><i>Class I Preventive Services</i> – \$0 (for premium and standard plans) \$12.50 person / \$37.50 family (for preventive plan) (for the half plan year)</p> <p><i>Class II Restorative and Class III Prosthetic Services</i> – \$12.50 person / \$37.50 family (for premium and standard plans) (for the half plan year) "Not Covered" (for preventive plan)</p>	<p>See the chart starting on page 3 for your costs for services this plan covers.</p> <p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u>.</p>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	This plan has no <u>out-of-pocket limit</u> .	Not applicable because there's no <u>out-of-pocket limit</u> on your expenses.

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Is there an overall annual limit on what the plan pays?	Yes. \$2,500 person (for premium plan) \$1,500 person (for standard plan) \$500 person (for preventive plan), except orthodontic services (which have a separate limit). \$2,000 person per lifetime for orthodontic services (for premium plan only)	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 3 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	No.	This plan treats providers the same in determining payment for the same services.
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If any **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- Your cost sharing does not depend on whether a **provider** is in a network.

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Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	15% (for premium and standard plans <i>Class II Restorative Services</i>), 25% (for premium plan <i>Class III Prosthetic Services</i>), 50% (for standard plan <i>Class III Prosthetic Services</i>), 50% (for premium plan orthodontic services) coinsurance for covered services listed in "Limitations & Exceptions" column.	Covered services under premium and standard plans only, limited to Class II restorative services, Class III prosthetic services, and orthodontic services.
	Specialist visit	Same as primary care visit above.	Same as primary care visit above.
	Other practitioner office visit	Not covered	Not covered
	Preventive care/screening/immunization	No charge	Covered services under premium, standard, and preventive plans limited to Class I preventive services, including: oral examinations; topical fluoride application (painting the surface of the teeth with a fluoride solution); prophylaxis, including cleaning, scaling, and polishing; and dental sealants for children through age 18.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Covered services under premium, standard, and preventive plans limited to Class I preventive services, including: dental X-rays required for the diagnosis of a specific condition and routine dental X-rays, but not more than one full mouth or series per year.

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	Imaging (CT/PET scans, MRIs)	Not covered	Not covered
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered
	Brand drugs	Not covered	Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered
	Physician/surgeon fees	15% coinsurance (for premium and standard plans <i>Class II Restorative Services</i>)	Covered services under premium and standard plans only limited to <i>Class II Restorative Services</i> , including: oral surgery, including surgical extractions, and apicoectomy (surgical removal of a root tip).
If you need immediate medical attention	Emergency room services	Not covered	Not covered
	Emergency medical transportation	Not covered	Not covered
	Urgent care	Not covered	Not covered
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered
	Physician/surgeon fee	Not covered	Not covered
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered
	Mental/Behavioral health inpatient services	Not covered	Not covered
	Substance use disorder outpatient services	Not covered	Not covered
	Substance use disorder inpatient services	Not covered	Not covered
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered
	Delivery and all inpatient services	Not covered	Not covered

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If you need help recovering or have other special health needs	Home health care	Not covered	Not covered
	Rehabilitation services	Not covered	Not covered
	Habilitation services	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered
	Hospice service	Not covered	Not covered
If your child needs dental or eye care	Eye exam	Not covered	Not covered
	Glasses	Not covered	Not covered
	Dental check-up	No charge	Covered services under premium, standard, and preventive plans limited to <i>Class I Preventive Services</i> , including: oral examinations; topical fluoride application (painting the surface of the teeth with a fluoride solution); prophylaxis, including cleaning, scaling, and polishing; and dental sealants for children through age 18.

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Excluded Services & Other Covered Services:**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Diagnostic tests, except as described in the preceding pages
- Drugs to treat your illness or condition
- Eye exams and glasses
- Hearing aids
- Help recovering or other special health needs (including home health care, rehabilitation or habilitation services, durable medical equipment, skilled nursing care, or hospice services)
- Hospital stays
- Imaging (CT/Pet Scans, MRIs)
- Immediate medical attention
- Infertility treatments
- Long-term care
- Mental health, behavioral health, or substance abuse needs
- Non-emergency care when traveling outside the U.S.
- Outpatient surgery, except as described in the preceding pages
- Pregnancy
- Private-duty nursing
- Routine eye care (Adult and Child)
- Routine foot care
- Visits to a health care provider's office or clinic, except as provided in the preceding pages
- Weight loss programs

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Dental care (Adult and Child), subject to limitations and exceptions described above and the terms of the Plan

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-821-2251. You may also contact the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the claims administrator at 1-877-517-6370 or the plan administrator at 1-800-821-2251 or:

HealthSmart
P.O. Box 99004
Anchorage, AK 99509-9004

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,020
- Patient pays \$520

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

(This condition is not covered under the dental plan, so patient pays 100%.)

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,340
- Patient pays \$1,060

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

(This condition is not covered under the dental plan, so patient pays 100%.)

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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