



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:
<p>What is the overall <u>deductible</u>?</p>	<p>\$150 person / \$300 family (for premium and standard plans) \$250 person / \$500 family (for economy plan) (for the half plan year). Doesn't apply to preventive care services from a <u>preferred provider</u> or <u>prescription drugs</u> purchased from a participating pharmacy.</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>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>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.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. \$175 person/\$350 family (for premium) \$600 person/\$1200 family (for standard), and \$1,000 person/\$2000 family (for economy) after <u>deductible</u> (for the half plan year). \$500 person/\$1,000 family for prescription drugs (for the half plan year).</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>

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<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, balance-billed charges, <u>prescription drug copayments</u>, expenses paid at a rate other than the normal <u>coinsurance</u>, expenses applied against <u>deductibles</u> or <u>copayments</u>, certification/plan referral penalties, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>
<p>Does this plan use a <u>network of providers</u>?</p>	<p>Yes. See the Provider Locator tool at <u>www.AlaskaCare.gov</u> or call 1-877-517-6370 or 1-866-720-3725 to locate <u>preferred providers</u>.</p>	<p>If you use an in-network doctor or other health care <u>provider</u>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u>, or participating for <u>providers</u> in their <u>network</u>. See the chart starting on page 3 for how this plan pays different kinds of <u>providers</u>.</p>
<p>Do I need a referral to see a <u>specialist</u>?</p>	<p>Yes. A plan referral or plan certification is required for: hospital or treatment facility stays; home health care or skilled nursing care services; outpatient psychiatric and chemical dependency treatment; and an MRI of the knee or spine. Call 1-877-517-6370 for certification of all services, except call 1-800-478-2812 for psychiatric or chemical dependency treatment.</p>	<p>This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u>.</p>
<p>Are there services this plan doesn't cover?</p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on page 11. See your policy or plan document for additional information about <u>excluded services</u>.</p>

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- **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**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	—————none—————
	Specialist visit	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	As previously noted in the chart, certain specialists require certifications. Failure to obtain those certifications may result in a reduction of benefits.
	Other practitioner office visit	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Coverage for services to diagnose and treat misalignment or dislocation of the spine and strained muscles or ligaments related to the spinal disorder is limited to \$750 annual max per person.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No charge	Same as Preferred Provider for other Non-preventive charges.	Preventive care, screening and immunizations not specifically identified as preventive services in the plan document are subject to 10% (for premium), 20% (for standard), 30% (for economy) coinsurance. Preventive services are limited to once per year.
If you have a test	Diagnostic test (x-ray, blood work)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	_____none_____
	Imaging (CT/PET scans, MRIs)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Certification is required for MRI of the knee or spine. If certification is not obtained, a \$200 penalty will be assessed before benefits are paid.

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.AlaskaCare.gov.</p>	<p>Generic drugs</p>	<p>20% coinsurance (retail), subject to minimum and maximum limits. <u>Retail minimum</u> – \$13 copay for up to 30-day supply; \$21 copay for 31-90-day supply. <u>Retail maximum</u> – \$61 copay for up to 30-day supply; \$122 copay for 31-90-day supply</p> <p>\$8 copayment (mail order)</p>	<p>40% coinsurance after deductible (retail and mail order)</p>	<p>Covers up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescription).</p> <p>\$500 Individual / \$1,000 Family annual copay maximum applies to following prescriptions up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescriptions).</p>

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Brand drugs	20% coinsurance (retail), subject to minimum and maximum limits. <u>Retail minimum</u> – \$13 copay for up to 30-day supply; \$21 copay for 31-90-day supply. <u>Retail maximum</u> – \$61 copay for up to 30-day supply; \$122 copay for 31-90-day supply \$20 copayment (mail order)	40% coinsurance after deductible (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescription) \$500 Individual / \$1,000 Family annual copay maximum applies to following prescriptions: up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescriptions).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Certification is required for all hospital stays. If certification is not obtained, a \$400 penalty will be assessed before benefits are paid.
	Physician/surgeon fees	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	_____none_____

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	A \$100 penalty will be assessed for non-emergency services received in an emergency room.
	Emergency medical transportation	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	_____none_____
	Urgent care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Failure to use preferred hospital will result in a 20% reduction in benefits and the out-of-pocket limit will be doubled. Certification is required for all hospital stays. If certification is not obtained, a \$400 penalty will be assessed before benefits are paid.
	Physician/surgeon fee	10%(for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	_____none_____

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

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Certification & plan referral required. Failure to obtain certification/plan referral will result in plan paying 50% of covered expenses and limit of 30 outpatient visits per plan year.
	Mental/Behavioral health inpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Certification & plan referral required. Failure to obtain certification/plan referral will result in plan paying 50% of covered expenses.
	Substance use disorder outpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Certification & plan referral required. Failure to obtain certification/plan referral will result in \$200 penalty.
	Substance use disorder inpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Certification & plan referral required. Failure to obtain certification/plan referral will result in \$400 penalty.
If you are pregnant	Prenatal and postnatal care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	<p style="text-align: center;">_____none_____</p>

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Delivery and all inpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Failure to use preferred hospital will result in a 20% reduction in benefits and the out-of-pocket limit will be doubled. Certification is required for all hospital stays. If certification is not obtained, a \$400 penalty will be assessed before benefits are paid.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Coverage is limited to 120 visits per plan year. Certification is required. If certification is not obtained, a \$200 penalty will be assessed before any benefits will be paid.
	Rehabilitation services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	_____none_____
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	Certification is required. If certification is not obtained, a \$200 penalty will be assessed before any benefits will be paid.
	Durable medical equipment	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as Preferred Provider.	_____none_____
	Hospice service	Not covered	Not covered	Not covered

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

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not covered	Not Covered	Not covered
	Glasses	Not covered	Not Covered	Not covered
	Dental check-up	Not covered	Not Covered	Not covered

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.)

- Dental care (Adult and Child) except as related to medical conditions of the teeth, jaw, and jaw joints as well as supporting tissues including bones, muscles, and nerves. Medical services include: inpatient hospital care, surgery, nonsurgical treatments/infections and disease supporting bones and/or gums, dental implants, services needed to treat accidental fractures, and diagnosis/appliance therapy regarding the jaw joints.
- Glasses
- Habilitation Services
- Hearing aids
- Hospice Care
- Infertility treatments
- Long-term care
- Routine eye care (Adult and Child)
- Routine foot care

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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.)

- Acupuncture (only if performed by a physician as a form of surgical anesthesia)
- Bariatric surgery
- Chiropractic care (subject to annual limit noted in the chart above)
- Cosmetic surgery (only for severe birth defects, disease, and to repair an injury resulting from an accident provided the treatment is started within 90 days of the accident)
- Non-emergency care when traveling outside the U.S. (excluding travel expenses)
- Private-duty nursing (provided by an R.N. or L.P.N. if medical condition requires skilled nursing services and visiting nursing care is inadequate)
- Weight loss programs

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.

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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 (assuming family coverage under the **premium** option). 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:

Deductibles	\$300
Copays	\$0
Coinsurance	\$220
Limits or exclusions	\$0
Total	\$520

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:

Deductibles	\$300
Copays	\$0
Coinsurance	\$760
Limits or exclusions	\$0
Total	\$1,060

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About these Coverage Examples:

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Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,600
- Patient pays \$940

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:

Deductibles	\$300
Copays	\$0
Coinsurance	\$640
Limits or exclusions	\$0
Total	\$940

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

- Amount owed to providers: \$5,400
- Plan pays \$4,100
- Patient pays \$1,300

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:

Deductibles	\$300
Copays	\$0
Coinsurance	\$1,000
Limits or exclusions	\$0
Total	\$1,300

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Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,000
- Patient pays \$1,540

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:

Deductibles	\$500
Copays	\$0
Coinsurance	\$1,040
Limits or exclusions	\$0
Total	\$1,540

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

- Amount owed to providers: \$5,400
- Plan pays \$3,750
- Patient pays \$1,650

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:

Deductibles	\$500
Copays	\$0
Coinsurance	\$1,150
Limits or exclusions	\$0
Total	\$1,650

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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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