



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, contact our office at (800) 821-2251. 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 [AlaskaCare.gov](#) or call (800) 821-2251 to request a copy.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>\$500/Individual or \$1,000/family</p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> services with an in-network provider, some primary care services, and some specialty care services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount, but a copayment may apply. For example, this <a href="#">plan</a> covers certain in-network <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="#">www.alaskacare.gov</a></p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>There are no separate <a href="#">deductibles</a> for specific services, however, you must pay any remaining balance on your annual deductible when using SurgeryPlus for non-emergent surgeries.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For <a href="#">network providers</a> \$2,750 individual / \$5,500 family; for <a href="#">out-of-network</a> facilities \$5,500 individual / \$11,000 family; <a href="#">prescription drug coverage</a>: individual \$1,000 / family \$2,000.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket</a> limit has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, penalties for non-emergency care at an emergency room of a hospital, precertification penalties, and health care services this <a href="#">plan</a> does not cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="#">AlaskaCare.gov</a> or call (855) 784-8646 for a list of network <a href="#">providers</a>.</p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without permission from this plan.</p>



- All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. [Copayments](#) do not apply to your [deductible](#), but do apply to your [out-of-pocket limit](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care physician visit	\$35 <a href="#">copay</a>	30% <a href="#">coinsurance</a> employee only; 70% dependents	<ul style="list-style-type: none"> <li>Facility charges, ancillary services and other services not billed as part of an office visit by the primary care physician will be subject to deductible and coinsurance.</li> <li>20% <a href="#">coinsurance</a> for hearing benefits.</li> <li>\$0 <a href="#">copay</a> (<a href="#">preventive care</a>); \$25 <a href="#">copay</a> (non-<a href="#">preventive care</a>)/Coalition Health Clinic (including associated lab work).</li> <li>\$0 <a href="#">copay</a>/Teladoc general medical consultation.</li> </ul>
	<a href="#">Specialist care physician</a> visit	\$55 <a href="#">copay</a>	30% <a href="#">coinsurance</a> employee only; 70% dependents	<ul style="list-style-type: none"> <li>Facility charges, ancillary services and other services not billed as part of an office visit by the specialist will be subject to deductible and coinsurance.</li> <li>Chiropractic care coverage is limited to 20 visits per calendar year.</li> <li>\$0 <a href="#">copay</a>/Teladoc dermatology consultation.</li> </ul>
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a> employee only; 70% dependents	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a> employee only; 70% dependents	50% <a href="#">coinsurance</a> facility services employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside of Alaska. . . Precertification is required for some imaging services when using of out-of-network providers. A \$400 benefit reduction applies if you fail to obtain precertification as required.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a> employee only; 70% dependents	50% <a href="#">coinsurance</a> facility services employee only; 70% dependents	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">AlakaCare.gov</a>	Maintenance generic prescription drugs	\$5 maximum <a href="#">copay</a> per prescription up to a 30 day supply; \$10 <a href="#">copay</a> per prescription via home delivery (31-90 day supply).	40% <a href="#">coinsurance</a>	Covers up to a 30-day supply (retail); Home Delivery can be used for a 90 day supply of any qualified prescription drug.  <a href="#">Specialty drugs</a> ; see preferred/non-preferred brand name drugs.
	Generic prescription drugs	\$10 maximum <a href="#">copay</a> per prescription up to a 30 day supply; \$20 <a href="#">copay</a> per prescription via home delivery (31-90 day supply).	40% <a href="#">coinsurance</a>	
	Preferred brand-name prescription drugs	\$35 maximum <a href="#">copay</a> per prescription up to a 30 day supply; \$50 <a href="#">copay</a> per prescription via home delivery (31-90 day supply).	40% <a href="#">coinsurance</a>	
	Non-preferred brand-name prescription drugs	35% <a href="#">coinsurance</a> with \$80 min / \$150 max per prescription up to a 30 day supply; \$100 <a href="#">copay</a> per prescription via home delivery (31-90 day supply).	40% <a href="#">coinsurance</a>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> employee only; 70% dependents	50% <a href="#">coinsurance</a> facility services employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. <a href="#">Pre-certification</a> is required for some services when using of out-of-network providers. A \$400 benefit reduction applies if you fail to obtain <a href="#">pre-certification</a> as required.  No cost after you meet your deductible for episode of care received through SurgeryPlus.
	Physician/surgeon fees	30% <a href="#">coinsurance</a> employee only; 70% dependents	30% <a href="#">coinsurance</a> employee only; 70% dependents	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a> employee only; 70% dependents	30% <a href="#">coinsurance</a> employee only; 70% dependents	30% <a href="#">coinsurance</a> after \$100 <a href="#">copay</a> /visit for non-emergency use.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> employee only; 70% dependents	30% <a href="#">coinsurance</a> employee only; 70% dependents	None
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a> employee only;	30% <a href="#">coinsurance</a>	None

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		70% dependents	employee only; 70% dependents	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> employee only; 70% dependents	50% <u>coinsurance</u> facility services employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. <u>Pre-certification</u> required for out-of-network care. A \$400 benefit reduction applies if you fail to obtain <u>pre-certification</u> as required.  No cost after you meet your deductible for episode of care received through SurgeryPlus.
	Physician/surgeon fees	30% <u>coinsurance</u> employee only; 70% dependents	30% <u>coinsurance</u> employee only; 70% dependents	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$55 <u>copay</u>	30% <u>coinsurance</u> employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. <u>Pre-certification</u> required for out-of-network care. A \$400 benefit reduction applies if you fail to obtain <u>pre-certification</u> as required.
	Inpatient services	30% <u>coinsurance</u> employee only; 70% dependents	50% <u>coinsurance</u> facility services employee only; 70% dependents	
<b>If you are pregnant</b>	Office visits	No charge	30% <u>coinsurance</u> employee only; 70% dependents	None
	Childbirth/delivery professional services	30% <u>coinsurance</u> employee only; 70% dependents	30% <u>coinsurance</u> employee only; 70% dependents	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. <u>Pre-certification</u> required for out-of-network care. A \$400 benefit reduction applies if you fail to obtain <u>pre-certification</u> as required. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	30% <u>coinsurance</u> employee only; 70% dependents	50% <u>coinsurance</u> facility services employee only; 70% dependents	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	30% <u>coinsurance</u> employee only; 70% dependents	30% <u>coinsurance</u> employee only; 70% dependents	Coverage is limited to 120 visits per calendar year. <u>Pre-certification</u> required for out-of-network care. A \$400 benefit reduction applies if you fail to obtain <u>pre-certification</u> as required.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u> employee only;	30% <u>coinsurance</u>	Coverage is limited to 20 visits per benefit year for spinal

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		70% dependents	employee only; 70% dependents	manipulations.
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a> employee only; 70% dependents	30% <a href="#">coinsurance</a> employee only; 70% dependents	None
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a> employee only; 70% dependents	30% <a href="#">coinsurance</a> employee only; 70% dependents	<a href="#">Pre-certification</a> required for out-of-network care. A \$400 benefit reduction applies if you fail to obtain <a href="#">pre-certification</a> as required.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a> employee only; 70% dependents	30% <a href="#">coinsurance</a> employee only; 70% dependents	None
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a> employee only; 70% dependents	30% <a href="#">coinsurance</a> employee only; 70% dependents	<a href="#">Pre-certification</a> required for out-of-network care. A \$400 benefit reduction applies if you fail to obtain <a href="#">pre-certification</a> as required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

### Excluded Services and Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- 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.
- Infertility treatment
- Long-term care
- Routine eye care (Adult and Child)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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- Bariatric surgery (one morbid obesity surgical procedure within a two year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.)
- Chiropractic care (20 visit limit per benefit year)
- Cosmetic surgery (Only to improve a significant functional impairment of a body part; to correct the result of an accidental injury; to correct the result of an injury that occurred during a covered surgical procedure within 24 months after the original injury; to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when the defect results in severe facial disfigurement, or the defect results in significant functional impairment and the surgery is needed to improve function.)
- Hearing Exam (once every 24 rolling months), 20% [coinsurance](#)
- Hearing Aids (maximum \$3,000 payable every 36 rolling months), 20% [coinsurance](#)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (provided by R.N. or L.P.N. if medical condition requires skilled nursing services and visiting nursing care is inadequate)
- Medical treatment of obesity including physical exam and diagnostic tests, weight loss prescription drugs and morbid obesity surgical procedures

**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: the plan at (855) 784-8646. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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 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 the claims administrator at (855) 784-8646, the plan administrator at (800) 821-2251, or:

Aetna  
 Attn: National Account CRT  
 P.O. Box 14079  
 Lexington, KY 40512-4079

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet 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:**

Para obtener asistencia en Español, llame al (855) 784-8646.  
 Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855) 784-8646.

如果需要中文的帮助, 请拨打这个号码 (855) 784-8646.  
 Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (855) 784-8646.

-----*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:



**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](#) \$500
- [Primary care physician visit copay](#) \$35
- [Specialty care physician visit copay](#) \$55
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$12,840</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$314
Copayment	\$770
Coinsurance	\$1,666
<i>What Isn't Covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,810</b>

### Managing Joe's Type-2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Primary care physician visit copay](#) \$35
- [Specialty care physician visit copay](#) \$55
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$7,460</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayment	\$990
Coinsurance	\$1,260
<i>What Isn't Covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,805</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Primary care physician visit copay](#) \$35
- [Specialty care physician visit copay](#) \$55
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,010</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$490
Copayment	\$165
Coinsurance	\$1,142
<i>What Isn't Covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,797</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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