




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, log into your account at [www.aseahealth.org](http://www.aseahealth.org) or call 1.866.553.8206. 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 in your Plan booklet, or request a copy by calling 1.866.553.8206.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$5,000/individual or \$10,000/family	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Some <a href="#">preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	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 <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	The Plan pays 100% of covered services after you meet the <a href="#">deductible</a> .	The <a href="#">deductible</a> is the most you could pay in a benefit year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	The plan pays 100% of covered services after you meet the <a href="#">deductible</a> .	
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Medical network providers in the Municipality of Anchorage are: Alaska Regional Hospital, Surgery Center of Anchorage, ACENT Ear Nose & Throat, Geneva Woods Birth Center, Chugach Physical Therapy, Ascension Physical Therapy, Alaska Fracture & Orthopedic and Alaska Hand	This <a href="#">plan</a> uses provider <a href="#">networks</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.

	Rehabilitation. In the Mat-Su Borough: Mat Su Regional Medical Center. For all other areas, the Aetna PPO Network. For a list of participating providers, see <a href="http://www.aetna.com">www.aetna.com</a> . For a list of participating pharmacy providers, see <a href="http://www.caremark.com">www.caremark.com</a> , see <a href="http://www.caremark.com">www.caremark.com</a> .	
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the specialist you choose without permission from this plan.

 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
		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 office visits to treat an injury or illness	No charge	No charge	None
	<a href="#">Specialist</a> visit	No charge	No charge	None
	<a href="#">Preventive care/screening/immunizations</a>	No charge for recommended services under PPACA; 20% <a href="#">coinsurance</a> for all other preventive services	40% <a href="#">coinsurance</a> for non-PPO facilities in the Municipality of Anchorage; all others same as network providers	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. And then check what your <a href="#">plan</a> will pay cover.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a> for non-PPO facilities in the Municipality of Anchorage; all others same as network providers	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a> for non-PPO facilities in the Municipality of Anchorage; all others same as network providers	May require <a href="#">preauthorization</a>

\* For more information about limitations and exceptions, see the plan or policy document at [www.aseahealth.org](http://www.aseahealth.org)

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="http://www.caremark.com">www.caremark.com</a>	Generic drugs (retail & mail order)	No charge	No charge	Up to a 90-day supply
	Preferred brand drugs (retail & mail order)	No charge	No charge	
	Non-preferred brand drugs (retail & mail order)	No charge	No charge	
	<a href="#">Specialty drugs</a>	No charge	No charge	Up to a 30-day supply; requires preauthorization
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a> for non-PPO facilities in the Municipality of Anchorage; all others same as network providers	<a href="#">May require preauthorization</a> . If you don't get <a href="#">preauthorization</a> , benefits could be reduced.
	Physician/surgeon fees	No charge	No charge	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No charge	20% <a href="#">coinsurance</a> for non-emergency services at non-PPO facilities in the Municipality of Anchorage; all others same as network providers	\$100 penalty for non-emergency services
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	No charge	20% <a href="#">coinsurance</a> for non-PPO facilities in the Municipality of Anchorage; all others same as network providers	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a> for non-PPO facilities in the Municipality of Anchorage; all others same as network providers	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced.
	Physician/surgeon fees	No charge	No charge	None

\* For more information about limitations and exceptions, see the plan or policy document at [www.aseahealth.org](http://www.aseahealth.org)

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 need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	<a href="#">May require preauthorization</a>
	Inpatient services	No charge	No charge	
If you are pregnant	Office visits (pre and postnatal care)	No charge	No charge	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a> for non-PPO facilities in the Municipality of Anchorage; all others same as network providers	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	No charge	120 visits/year
	<a href="#">Rehabilitation services</a>	No charge	20% <a href="#">coinsurance</a> for non-PPO facilities in the Municipality of Anchorage; all others same as network providers	No limit for rehabilitation services to restore and improve bodily functions lost due to injury or illness. Limit of 20 visits per year for chiropractic, massage therapy and acupuncture services combined.
	<a href="#">Habilitation services</a>	Not covered	Not covered	No coverage for habilitation services except following cochlear implants
	<a href="#">Skilled nursing care</a>	No charge	No charge	<a href="#">Preauthorization</a> is required
	<a href="#">Durable medical equipment</a>	No charge	No charge	None
	<a href="#">Hospice services</a>	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	Only pediatric vision and oral services are covered to the extent required by the Affordable Care Act.		
	Children's glasses			
	Children's dental exams			

#### 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](#).)

• Custodial care	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Work-related services for treatment for on-the-job injuries
• Experimental or investigational services	• Private duty nursing	

\* For more information about limitations and exceptions, see the plan or policy document at [www.aseahealth.org](http://www.aseahealth.org)

**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
- Non-emergency care when traveling outside the U.S. (must be in an accredited facility)
- Weight Loss Programs (under medical supervision)

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1.866.444.3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the Center for Medicare and Medicaid Services at 1.877.267.2323, x61565 for the Health Insurance Hotline 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 Health Trust Administrator at 1.866.553.8206.

**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 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 1.866.874.3972, # 781115

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.866.874.3972, # 781115

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

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](#) \$5,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,060</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$5,055</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$5,000
- [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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>