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. 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 www.kpbsd.rehnonline.com or call 1-800-872-8979 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 Individual* / $3,000 Family	The family deductible must be met before the plan begins to pay. *If there is only one person enrolled on the plan, they must meet the individual deductible before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet separate deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,000 Individual / $4,000 Family	Out-of-pocket limit does not apply to Out-of-Network Facility charges. Out-of-pocket limit plus the deductible, coinsurance, and prescription drugs, shall not exceed the current year's ACA limit.
What is not included in the out-of-pocket limit?	Copayments, premiums, balance-billed charges, deductibles, emergency room copay, utilization review noncompliance penalties, coinsurance for services at a non-PPO facility and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. Participating facilities include Central Peninsula Hospital, South Peninsula Hospital, Alaska Regional Hospital and Surgery Center of Anchorage. The contracted National Network is Aetna Choice POS II. Other hospital facilities, freestanding imaging centers and freestanding outpatient surgery centers within the Municipality of Anchorage shall be considered Out-of-Network, regardless of whether they are included in other PPO Networks, such as Aetna.	This plan uses a provider network that includes participating facilities. The Preferred Providers for inpatient and outpatient hospital services within the Municipality of Anchorage will be Alaska Regional Hospital and the Surgery Center of Anchorage. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill (balance billing) from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	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 provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	Balance Billing may occur when utilizing an out-of-network provider.
	Specialist visit	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	
	Preventive care/screening/ immunization	No Charge	No Charge, unless provider charges more than usual, customary & reasonable (UCR)	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	If Services Are Rendered in Anchorage but NOT at one of the In-Network facilities listed, HCCMA Penalty applies as Patient balance, Then Subject to Deductible then 60% (No OOP Applies) - All Other Cities or States: Deductible, 60% of UCR Amount (No OOP Applies)
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$5 Copay after deductible	$5 Copay after deductible	Up to a 100-day or 100-unit supply. Specialty medications are limited to a 30-day supply. If you choose a brand-name medication when a generic equivalent is available, you will pay the difference in cost between the brand name and the generic, plus your brand name copay. Reimbursement at a Non-Participating Provider is based upon the amount the Plan pays at a Participating Pharmacy.
	Preferred brand drugs	$25 Copay after deductible	$25 Copay after deductible	
	Non-preferred brand drugs	$50 Copay after deductible	$50 Copay after deductible	
	Specialty drugs	$100 Copay after deductible	$100 Copay after deductible	
	*Medical deductible must be met prior to these copays taking effect.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	This service may require a preauthorization be obtained. Please have your Provider contact Aetna, (888) 632-3862, for precertification / utilization review. If Services Are Rendered in Anchorage but NOT at one of the In-Network facilities listed, HCCMA Penalty applies as Patient balance, Then Subject to Deductible then 60% (No OOP Applies) - All Other Cities or States: Deductible, 60% of UCR Amount (No OOP Applies)
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at www.kpbsd.rehnonline.com.]

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 immediate medical attention	Emergency room care	$250 Copay + Deductible + 20% Coinsurance	$250 Copay + Deductible + 40% Coinsurance (non-emergency); 20% Coinsurance (emergency)	Copay waived if directly admitted, or treatment is for accidental injury and is received on the day of or within 2 days after the accident.
	Emergency medical transportation	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	
	Urgent care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	This service may require a preauthorization be obtained. Please have your Provider contact Aetna, (888) 632-3862, for precertification / utilization review. If Services Are Rendered in Anchorage but NOT at one of the In-Network facilities listed, HCCMA Penalty applies as Patient balance, Then Subject to Deductible then 60% (No OOP Applies) - All Other Cities or States: Deductible, 60% of UCR Amount (No OOP Applies)
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	
	Inpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	This service may require a preauthorization be obtained. Please have your Provider contact Aetna, (888) 632-3862, for precertification / utilization review. If Services Are Rendered in Anchorage but NOT at one of the In-Network facilities listed, HCCMA Penalty applies as Patient balance, Then Subject to Deductible then 60% (No OOP Applies) - All Other Cities or States: Deductible, 60% of UCR Amount (No OOP Applies)
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	Dependent Maternity not covered.
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	

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 help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	1 visit per day for 100 visits per calendar year. Must be homebound.
	Rehabilitation services	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	Chiropractic and Rolfing services combined are limited to 20 visits per calendar year; Acupuncture limited to 20 visits per calendar year; Physical Therapy limited to 24 visits per calendar year.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	20% Coinsurance	20% Coinsurance	90-day limit per calendar year
	Durable medical equipment	20% Coinsurance	20% Coinsurance	This service may require a preauthorization be obtained. Please have your Provider contact Aetna, (888) 632-3862, for precertification / utilization review.
	Hospice services	20% Coinsurance	20% Coinsurance	
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	20% Coinsurance	Maximum benefit of 1 exam per calendar year.
	Children's glasses	20% Coinsurance	20% Coinsurance	Frames: 1 Every 2 Calendar years up to $100 max Lenses or Contacts: 1 set per calendar year
	Children's dental check-up	Covered under Dental Plan	Covered under Dental Plan	

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.)

- Cosmetic surgery
- Habilitation services
- Hearing aids
- Infertility treatment
- Long term care
- Private duty nursing
- Speech Therapy
- Weight loss programs
- Wigs

The Covered Person is responsible for any charges that exceed the Usual & Customary amount as well as for any charges in excess of stated benefit maximums and services and supplies not covered under this Plan.

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
- Massage Therapy
- Non-emergency care when traveling outside the U.S.
- Rolfing
- Routine eye care (adult)
- Routine foot care
- Foot Orthotics

[* For more information about limitations and exceptions, see the plan or policy document at www.kpbsd.rehnonline.com.]

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact the plan at (509) 534-0600 or toll free at (800) 872-8979. 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: Rehn & Associates, Appeals Department, PO Box 5433, Spokane, WA 99205, Phone (509) 534-0600, Toll Free (800) 872-8979.

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 1-800-872-8979.

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

[* For more information about limitations and exceptions, see the plan or policy document at www.kpbsd.rehnonline.com.]

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	$1,500
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$2,240
What isn't covered	
Limits or exclusions, OTC drug	$60
The total Peg would pay is	**$3,800**

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

The plan's overall deductible	$1,500
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Rx Copayments	$400
Coinsurance	$90
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,010**

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

The plan's overall deductible	$1,500
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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