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| **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, call 1-800-676-1411 (TTY: 711) or visit us at aka.ms/benefits. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-676-1411 (TTY: 711) to request a copy. |

| **Important Questions** | **Answers** | **Why This Matters:** |
| --- | --- | --- |
| **What is the overall deductible?** | In and Out of Network Combined - **$300** per person, **$900** family maximumDoes not apply to preventive carefor well childcare through 6 | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Does not apply to services listed below as "No charge" | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. 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 deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Yes. In and Out of Network Combined - **$1,500** per person, **$4,500** per family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in****the out-of-pocket limit?** | Premium, balance-billed charges, 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. See **premera.com or call 1-800-676-1411** for a list of network providers. | This plan uses a provider network. 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 from a provider for the difference between the provider’s charge and what your plan pays (balance billing). 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 a referral. |

|  | 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 | 10% coinsurance | 30% coinsurance | None |
| Specialist visit | 10% coinsurance | 30% coinsurance | None |
| Preventive care/screening/immunization | No charge | 30% coinsurance age 7 and aboveNo charge age 6 and under | 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 use an out-of-network provider, you may be responsible for balance billing. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 10% coinsurance | None |
| Imaging (CT/PET scans, MRIs)  | 10% coinsurance | 10% coinsurance | Prior authorization recommended for some outpatient imaging tests. |
| **If you need drugs to treat your illness or condition**More information about **prescription drug coverage** is available [here](http://www.premera.com/documents/066481_2026.pdf) | Generic drugs | 10% coinsurance | 10% coinsurance | Retail up to a 30-day supply/generic maintenance up to 90 days. Mail order up to 90-day supply. Prior authorization required for some drugs.  |
| Preferred brand drugs | 10% coinsurance | 10% coinsurance | Retail up to a 30-day supply / mail order up to a 90-day supply. Prior authorization required for some drugs.  |
| Non-preferred brand drugs | 10% coinsurance | 10% coinsurance |
| Specialty drugs | 10% coinsurance | Not Covered | Covers up to a 30-day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.  |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | Prior authorization recommended for some services. |
| Physician/surgeon fees | 10% coinsurance | 30% coinsurance | Prior authorization recommended for some services. |
| **If you need immediate medical attention** | Emergency room care | 10% coinsurance | 10% coinsurance | None |
| Emergency medical transportation | 10% coinsurance | 10% coinsurance | Prior authorization recommended for some services. |
| Urgent care | 10% coinsurance | 30% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | Prior authorization recommended for all planned inpatient stays. |
| Physician/surgeon fees | 10% coinsurance | 30% coinsurance | Prior authorization recommended for all planned inpatient stays. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 10% coinsurance | 10% coinsurance | None |
| Inpatient services | 10% coinsurance | 10% coinsurance | Prior authorization recommended for all planned inpatient stays. |
| **If you are pregnant** | Office visits | 10% coinsurance | 30% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). |
| Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). |
| Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance | None |
| Rehabilitation services | 10% coinsurance | 30% coinsurance | Includes physical therapy, speech therapy, and occupational therapy. Outpatient services limited to one hour per specialty per day. |
| Habilitation services | 10% coinsurance | 30% coinsurance | Includes physical therapy, speech therapy, and occupational therapy. Outpatient services limited to one hour per specialty per day. |
| Skilled nursing care | 10% coinsurance | 30% coinsurance | Prior authorization recommended for all planned inpatient stays or partial hospital care services. 120-day limit.  |
| Durable medical equipment | 10% coinsurance | 10% coinsurance | None |
| Hospice services | 10% coinsurance | 10% coinsurance | None |
| **If your child needs dental or eye care** | Children’s eye exam | Not covered | Not covered | None |
| Children’s glasses | Not covered | Not covered | None |
| Children’s dental check-up | Not covered | Not covered | None |

**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 (except as covered under the Reconstructive Surgery Benefit)
* Dental care (Adult)
 | * Long-term care
* Routine eye care (Adult)
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| --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**  |  |  |
| * Acupuncture
* Infertility treatment
* Bariatric surgery
* Chiropractic care or other spinal manipulations
 | * Routine foot care
* Hearing aids
* Non-emergency care when traveling outside the U.S.
 | * Private-duty nursing
* Weight loss program
 |

**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: for ERISA plans, contact the Department of Labor’s Employee Benefit’s Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#plan). For more information about your rights, this notice, or assistance, contact: your plan at 1-800-676-1411or TTY 711, or the state insurance department at 1-800-562-6900,or Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/%22%20%5Cl%20%22minimum-essential-coverage%22%20%5Ct%20%22_blank)generally includes [plans](https://www.healthcare.gov/sbc-glossary/#plan), [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits).

**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 1-800-676-1411.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-676-1411.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-676-1411.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-676-1411.

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



**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.

**About these Coverage Examples:**

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

◼ **The plan’s overall deductible** **$300**

◼ **Specialist coinsurance 10%**

◼ **Hospital (facility) coinsurance 10%**

◼ **Other** **coinsurance 10%**

**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 | $300 |
| Copayments | $0 |
| Coinsurance | $1,240 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$1,540** |

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

◼ **The plan’s overall deductible** **$300**

◼ **Specialist coinsurance 10%**

◼ **Hospital (facility) coinsurance 10%**

◼ **Other** **coinsurance 10%**

**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 | $300 |
| Copayments | $0 |
| Coinsurance | $530 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$830** |

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

◼ **The plan’s overall deductible** **$300**

◼ **Specialist coinsurance 10%**

◼ **Hospital (facility) coinsurance 10%**

◼ **Other** **coinsurance 10%**

**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:**

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| --- |
| *Cost Sharing* |
| Deductibles | $300 |
| Copayments | $0 |
| Coinsurance | $250 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$550** |

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