
 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 Plan Booklet/Summary Plan Description and Summary Material Modifications, visit [www.k12northstar.org/Benefits](http://www.k12northstar.org/Benefits) or call 1-800-331-6158, option 8. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-331-6158, option 8 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$3,000</b> per person/ <b>\$6,000</b> per family. Common Accident: \$3,000 per 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> ?	<b>Yes.</b> Preventive care, outpatient prescription drug charges, 2 <sup>nd</sup> and 3 <sup>rd</sup> surgical opinions, hearing aid and exam, dental and vision benefit 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 cost sharing 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?	<b>No.</b>	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical Preferred Provider: <b>\$2,000</b> per person / <b>\$4,000</b> per family. Medical Non-Preferred: <b>\$4,000</b> per person / <b>\$8,000</b> per family. <u>Prescription Drug</u> : <b>\$1,500</b> per person / <b>\$3,000</b> per family.	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 limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <a href="#">plan</a> does not cover, the deductible, certain prescriptions, emergency room penalty, and penalty for failure to obtain <u>preauthorization</u> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you	<b>Yes.</b> See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a>	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> .

use a <a href="#">network provider</a> ?	and select "Aetna Choice® POS II (Open Access) Network for a list of <a href="#">network providers</a> . Preferred hospital in Matanuska-Susitna Borough is Mat-Su Regional Medical Center. For the Coalition Health Center call 907-264-1370.	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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$10 <a href="#">copay</a> for services at the Coalition Health Center. Acupuncture and acupressure treatment limited to 12 visits per year. Non-PPO penalties apply for services at non-PPO facilities in Alaska and all non-PPO providers outside Alaska.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Non-PPO penalties apply for services at non-PPO facilities in Alaska and all non-PPO providers outside Alaska. Allowable charges for services at a non-preferred facility in the Municipality of Anchorage are limited.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred 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: \$5 <a href="#">copay</a> /prescription; Mail Order: No charge	40% <a href="#">coinsurance</a>	Covers up to a 30-day supply for a retail prescription and 31-90 day supply for a mail order prescription. Non-participating pharmacy coinsurance does not apply to the prescription drug <u>out-of-pocket limit</u> . 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 <a href="#">copay</a> , not subject to the <u>out-of-pocket limit</u> .
	Preferred brand drugs	Retail: \$30 <a href="#">copay</a> /prescription + 15% <a href="#">coinsurance</a> ; Mail Order: \$60 <a href="#">copay</a> /prescription + 15% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Non-preferred brand drugs	Retail: \$60 <a href="#">copay</a> /prescription + 20% <a href="#">coinsurance</a> ; Mail Order: \$100 <a href="#">copay</a> /prescription + 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	\$100 <a href="#">copay</a> /prescription	40% <a href="#">coinsurance</a>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Non-PPO penalties apply for services at non-PPO facilities in Alaska and all non-PPO providers outside Alaska. Allowable charges for services at a non-preferred facility in the Municipality of Anchorage are limited
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	An additional penalty of \$500 may be applied to each emergency room visit that occurs during the hours of operation of the Coalition Health Center.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<u>Preauthorization</u> is required. Plan will not pay the first \$250 of charges if <u>preauthorization</u> is not obtained. In addition, expenses will be paid at the lesser of 70% of Allowable Charges, or the Plan's Reimbursement Percentage, until the maximum penalty totals \$1,000. Non-PPO penalties apply for services at non-PPO facilities in Alaska and
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				all non-PPO providers outside Alaska. Allowable charges for services at a <u>Non-preferred</u> facility in the Municipality of Anchorage are limited
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Substance abuse outpatient services limited to alcohol only. Marriage and family counseling are not covered. Inpatient stay must be <u>preauthorized</u> . Plan will not pay the first \$250 of charges if <u>preauthorization</u> is not obtained. In addition, expenses will be paid at the lesser of 70% of Allowable Charges, or the Plan's Reimbursement Percentage, until the maximum penalty totals \$1,000. Non-PPO penalties apply for services at non-PPO facilities in Alaska and all non-PPO providers outside Alaska. Allowable charges for services at a non-preferred facility in the Municipality of Anchorage are limited
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Non-PPO penalties apply for services at Non-PPO facilities in Alaska and all Non-PPO providers outside Alaska. Allowable charges for services at a non-preferred facility in the Municipality of Anchorage are limited.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Occupational, Speech and Hearing Therapy limited to a combined total of 24 visits per year. Chiropractic care limited to 24 visits per year. Extended Care and Skilled Nursing Facility limited to 90 days per year. <u>Preauthorization</u> required for any inpatient
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				stays, home health care and hospice care. Plan will not pay the first \$250 of charges if <u>preauthorization</u> is not obtained. In addition, expenses will be paid at the lesser of 70% of Allowable Charges, or the Plan's Reimbursement Percentage, until the maximum penalty totals \$1,000. Non-PPO penalties apply for services at non-PPO facilities in Alaska and all non-PPO providers outside Alaska.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge <u>Deductible</u> does not apply.	Charges over the excess of \$102	<b>Your child is only covered if you have elected vision coverage and paid the appropriate premium.</b> Vision coverage is provided through VSP. Vision Exam limited to one per calendar year. Glasses or contacts limited to one set per calendar year. Frames limited to one pair every two calendar years.
	Children's glasses	No charge for single vision lenses; covered up to \$200 for contact lenses; covered up to \$120 for frames.	All costs over the excess of \$75 for single vision lenses; \$185 for contact lenses; \$90 for frames	
	Children's dental check-up	No cost for preventive and diagnostic.	No cost for preventive and diagnostic.	<b>Your child is only covered if you have dental coverage and paid the appropriate premiums.</b> \$50 per participant <u>deductible</u> waived for preventive and diagnostic procedures.

### 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 to correct function disorder)
- Custodial care in a psychiatric hospital or alcoholism treatment facility
- Drug dependency or abuse treatment
- Marriage and family counseling
- Newborn charges of a dependent child

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

- Acupuncture
- Infertility Treatment (diagnostic procedures, prescriptions and related health provider fees)
- Private duty nursing
- Bariatric Surgery
- Routine eye care (adult)

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|--|---|---|
| <ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Dental Care (Adult)</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care (must be medically necessary level of care)</li> <li>• Non-emergency care when traveling outside the U.S. if hospital is accredited by the Joint Commission International.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
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**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/healthreform](http://www.dol.gov/ebsa/healthreform) and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x 61565 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or contact the Administration Office at 1-800-331-6158.

**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 1-800-331-6158.

\_\_\_\_\_ *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](#) \$3,000
- [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	\$2,800
Copayments	\$20
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,080</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [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	\$2,300
Copayments	\$500
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,460</b>

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

- The [plan's](#) overall [deductible](#) \$3,000
- [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	\$1,500
Copayments	\$0
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>