
 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, phone Tongass Timber Trust at 907-225-6114 or online at [www.akforest.org](http://www.akforest.org). 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.akforest.org](http://www.akforest.org) or call 1-907-225-6114 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$750 Individual / \$2,250 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. <a href="#">Preventive care</a> is 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. 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> ?	\$1,900 individual / \$4,500 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> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain pre-authorization for services and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Does this plan use a <a href="#">network of provider</a> ?	No.	This <a href="#">plan</a> treats <a href="#">provider</a> s the same in determining payment for the same services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see a <a href="#">specialist</a> 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	Your Cost		Limitations, Exceptions, & Other Important Information
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>		None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>		None
	<a href="#">Preventive care/screening/immunization</a>	No charge		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)	20% <a href="#">coinsurance</a>		None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>		
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.akforest.org">www.akforest.org</a>	Generic drugs	20% <a href="#">coinsurance</a>		Covers up to a 90-day supply.
	Preferred brand drugs	40% <a href="#">coinsurance</a>		
	<a href="#">Specialty drugs</a>	40% <a href="#">coinsurance</a>		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>		None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>		None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>		None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>		None
	<a href="#">Emergency Airlift transportation</a>	20% <a href="#">coinsurance</a>		Upon arrival at the treating facility, the patient must remain a registered bed patient for at least 24 hours. Benefits are limited to one Airlift every 12 months.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>		<a href="#">Preauthorization</a> is required for all inpatient admissions. An additional \$200 copay will apply for unauthorized admissions.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>		None

Common Medical Event	Services You May Need	Your Cost		Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>		None
	Inpatient services	20% <a href="#">coinsurance</a>		
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>		<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	20% <a href="#">coinsurance</a>		
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>		
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>		Limited to 60 visits per year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>		Physician prescription is required.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>		
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>		None
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>		Excludes home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>		Lifetime maximum is 6 months.
If your child needs dental or eye care	Children's eye exam	10% <a href="#">coinsurance</a>		Coverage limited to one eye exam every 12 months.
	Children's glasses	No <a href="#">coinsurance</a>		Coverage limited to one set of lenses every 12 months and one frame every 24 months.
	Children's dental check-up	20% <a href="#">coinsurance</a>		Limited to one check-up every 6 months.

### 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](#).)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Infertility Treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private Duty Nursing</li> </ul> |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture (if prescribed for rehabilitation purposes)</li> <li>• Bariatric Surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Weight Loss Programs</li> </ul> | <ul style="list-style-type: none"> <li>• Adult Routine eye care</li> <li>• Adult Routine foot care</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: Tongass Timber Trust at 907-225-6114. You may also contact your state insurance department, the 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 US Department of Health and Human Services 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: Tongass Timber Trust at 907-225-6114. You may also contact 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). For questions about your rights, this notice or assistance, you can contact the State of Alaska Insurance Department at 907-279-7900. Additionally, a consumer assistance program can help you file your appeal.

**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](#).

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

## About these Coverage



**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](#) \$750
- 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	\$750
Copayments	\$0
Coinsurance	\$2,410
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,160</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$750
- 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	\$750
Copayments	\$0
Coinsurance	\$1330
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,080</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$750
- 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*	\$750
Copayments	\$0
Coinsurance	\$230
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$980</b>

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.