⚠ 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. 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 or call 1-907-225-6114 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750 Individual / $2,250 family	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the 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	
What is the out-of-pocket limit for this plan?	$1,900 individual / $4,500 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?	Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Does this plan use a network of provider ?	No.	This plan treats providers the same in determining payment for the same services.
Do you need a referral to see a specialist?	No.	You can see a 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	Your Cost		Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance		None
	Specialist visit	20% coinsurance		None
	Preventive care/screening/ immunization	No charge		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)	20% coinsurance		None
	Imaging (CT/PET scans, MRIs)	20% coinsurance		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.akforest.org	Generic drugs	20% coinsurance		Covers up to a 90-day supply.
	Preferred brand drugs	40% coinsurance		
	Specialty drugs	40% coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance		None
	Physician/surgeon fees	20% coinsurance		None
If you need immediate medical attention	Emergency room care	20% coinsurance		None
	Emergency medical transportation	20% coinsurance		None
	Emergency Airlift transportation	20% coinsurance		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% coinsurance		Preauthorization is required for all inpatient admissions. An additional $200 copay will apply for unauthorized admissions.
	Physician/surgeon fees	20% coinsurance		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% coinsurance		None
	Inpatient services	20% coinsurance		
If you are pregnant	Office visits	20% coinsurance		Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance		
	Childbirth/delivery facility services	20% coinsurance		
If you need help recovering or have other special health needs	Home health care	20% coinsurance		Limited to 60 visits per year.
	Rehabilitation services	20% coinsurance		Physician prescription is required.
	Habilitation services	20% coinsurance		
	Skilled nursing care	20% coinsurance		None
	Durable medical equipment	20% coinsurance		Excludes home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance		Lifetime maximum is 6 months.
If your child needs dental or eye care	Children's eye exam	10% coinsurance		Coverage limited to one eye exam every 12 months.
	Children's glasses	No coinsurance		Coverage limited to one set of lenses every 12 months and one frame every 24 months.
	Children's dental check-up	20% coinsurance		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.)

- Cosmetic Surgery
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Chiropractic Care
- Weight Loss Programs
- Adult Routine eye care
- Adult Routine foot care

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 or the US Department of Health and Human Services at 1-877-267-2323 x 61565 or 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 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. 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.

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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$2,410
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,160

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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1330
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,080

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)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$750
Copayments	$0
Coinsurance	$230
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$980

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

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