


**⚠** 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<br>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> |  | None   |
|   | <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](#).)

- 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](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> |
|---------------------------|-----------------|

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> |
|---------------------------|----------------|

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> |
|---------------------------|----------------|

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.