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 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 or call 1-800-331-6158, option 8 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** per person/**$3,000** per family. Common Accident: $1,000 per 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, outpatient prescription drug charges, 2nd and 3rd surgical opinions, hearing aid exam, dental and vision benefit services are covered before you meet your deductible.	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?	Medical Preferred Providers: **$2,000** per person / $**6,000** per family. Medical Non-Preferred Facility in Alaska / Non-Preferred Providers outside Alaska: **$4,000** per person / **$12,000** per family. Prescription Drug: $**1,500** per person / **$3,000** 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?	Premiums, balance-billed charges, health care this plan does not cover, the deductible, certain prescriptions, emergency room penalty, and penalty for failure to obtain preauthorization.	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 www.aetna.com/docfind and select "Aetna Choice® POS II (Open Access) Network for a list of network providers. Preferred hospital in Matanuska-Susitna Borough is Mat-Su Regional Medical Center. Preferred Facilities in the Municipality of Anchorage are Alaska Regional Hospital and the Surgery Center of Anchorage. For the Coalition Health Center call 907-264-1370.	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
		Preferred Provider (You will pay the least)	Non-Preferred 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	20% coinsurance	40% coinsurance	$10 copay 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.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No Charge Deductible does not apply.	40% coinsurance	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 and the Mat-Su Borough are limited. 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	40% coinsurance	Non-PPO penalties apply for services at non-PPO facilities in Alaska and all non-PPO

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)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	providers outside Alaska. Allowable charges for services at a non-preferred facility in the Municipality of Anchorage are limited.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail: $5 copay/prescription; Mail Order: No charge	40% coinsurance	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 out-of-pocket limit. 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 copay, not subject to the out-of-pocket limit. Prior authorization is required for Specialty drugs, limited to a 30-day supply.
	Preferred brand drugs	Retail: $30 copay/prescription + 15% coinsurance; Mail Order: $60 copay/prescription + 15% coinsurance	40% coinsurance	
	Non-preferred brand drugs	Retail: $60 copay/prescription + 20% coinsurance; Mail Order: $100 copay/prescription + 20% coinsurance	40% coinsurance	
	Specialty drugs	$100 copay/prescription	40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	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% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	40% coinsurance	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.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. Plan will not pay the first $250 of charges if preauthorization 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
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

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)	
				$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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Substance abuse outpatient services limited to alcohol only. Marriage and family counseling are not covered. Inpatient stay must be preauthorized. Plan will not pay the first $250 of charges if preauthorization 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% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost-sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	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. Newborn of a dependent child is not covered.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have	Home health care	20% coinsurance	40% coinsurance	Occupational, Speech and Hearing Therapy limited to a combined total of 24 visits per year. Chiropractic care limited to 24 visits per
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	

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)	
other special health needs	Skilled nursing care	20% coinsurance	40% coinsurance	year. Extended Care and Skilled Nursing Facility limited to 90 days per year. Preauthorization required for any inpatient stays, home health care and hospice care. Plan will not pay the first $250 of charges if preauthorization 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.
	Durable medical equipment	20% coinsurance	20% coinsurance	
	Hospice services	20% coinsurance	40% coinsurance	
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply.	Charges over the excess of $102	**Your child is only covered if you have elected vision coverage and paid the appropriate premium.** 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.	**Your child is only covered if you have dental coverage and paid the appropriate premiums.** $50 per participant deductible 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 • Bariatric Surgery • Chiropractic Care • Dental Care (Adult) • Hearing aids	• Infertility Treatment (diagnostic procedures, prescriptions and related health provider fees) • Long-term care (must be medically necessary level of care) • Non-emergency care when traveling outside the U.S. if hospital is accredited by the Joint Commission International.	• Private duty nursing • Routine eye care (adult) • Routine foot care • Weight loss programs

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 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. 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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	$1,000
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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$20
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,080**

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

The plan's overall deductible	$1,000
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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,260**

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

The plan's overall deductible	$1,000
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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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