- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If any **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	——————none——————
	Specialist visit	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid.	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Other practitioner office visit	10% (for premium), 20% (for standard), 30% (for economy) coinsurance 20% coinsurance for audio benefits for all plans.	Same as in-network provider.	Coverage for chiropractic services is limited to 20 visits per benefit year.
	Preventive care/screening/immunization	No charge	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Preventive care, screening and immunizations not specifically identified as preventive services in the plan document are subject to 10% (for premium), 20% (for standard), 30% (for economy) coinsurance. Preventive services are limited to once per year.
If you have a test	Diagnostic test (x-ray, blood work)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Pre-certification is required for some imaging services when using of out-of-network providers. Failure to obtain pre-certification when required will result in a $400 penalty being assessed before benefits are paid. See your plan document for additional information about pre-certification. Call **1-855-784-8646** for pre-certification.	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.AlaskaCare.gov or by calling **1-855-784-8646.**	Generic & Brand Drugs	20% coinsurance (retail), subject to minimum and maximum limits. Retail minimum: $13 copay for up to 30-day supply; $21 copay for 31-90-day supply. Retail maximum: $61 copay for up to 30-day supply; $122 copay for 31-90-day supply. Mail order: $8 copayment (generic). $20 copayment (brand).	40% coinsurance (retail and mail order).	Covers up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescription). **$1,000** person/**$2,000** person annual copay maximum applies to following prescriptions: up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescriptions).

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Specialty drugs	20% coinsurance (retail), subject to minimum and maximum limits. Retail minimum: $13 copay for up to 30-day supply; $21 copay for 31-90-day supply. Retail maximum: $61 copay for up to 30-day supply; $122 copay for 31-90-day supply. Mail order: $20 copayment.	40% coinsurance (retail and mail order). Pre-certification is required for some specialty drugs when using of out-of-network providers. Failure to obtain pre-certification when required will result in a $400 penalty being assessed before benefits are paid. See your plan document for additional information about pre-certification. Call **1-855-784-8646** for pre-certification.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescription). **$1,000** person / **$2,000** person annual copay maximum applies to following prescriptions: up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescriptions).

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid.	——————none——————
	Physician/surgeon fees	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	——————none——————
If you need immediate medical attention	Emergency room services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	A $100 penalty will be assessed for non-emergency services received in an emergency room.
	Emergency medical transportation	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	——————none——————
	Urgent care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid.	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Failure to use preferred hospital will result in a 20% reduction in benefits and the out-of-pocket limit will be doubled.
	Physician/surgeon fee	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	————————none————————
	Mental/Behavioral health inpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid. Use of a out-of-network provider will result in 20% reduction in benefits.	————————none————————
	Substance use disorder outpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid. Use of an out-of-network provider will result in 20% reduction in benefits.	——————none——————
If you are pregnant	Prenatal and postnatal care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid.	Use of designated preferred hospital is required for non-emergency care in Anchorage and outside Alaska. Failure to use preferred hospital will result in a 20% reduction in benefits and the out-of-pocket limit will be doubled.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid.	Coverage is limited to 120 visits per plan year.
	Rehabilitation services	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	——————none——————
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Pre-certification is required for use of out-of-network providers. Failure to obtain pre-certification will result in a $400 penalty being assessed before benefits are paid.	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Durable medical equipment	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	——————none——————
	Hospice service	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not covered	Not Covered	Not covered
	Glasses	Not covered	Not Covered	Not covered
	Dental check-up	0% for preventive services (for preventive and standard plans), 90% for basic services (for preventive plan), 20% for basic services (for standard plan), 90% for major services (for preventive plan), 50% for major services (for standard plan), 50% for orthodontic services (for standard plan) coinsurance.	Same as in-network provider.	$1,000 individual lifetime maximum for orthodontics