



- **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 <u>provider's</u> 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_____

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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.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	10% (for premium), 20% (for standard), 30% (for economy) coinsurance	Same as in-network provider.	—————none—————

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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	<p>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.</p> <p>See your plan document for additional information about pre-certification. Call <b>1-855-784-8646</b> for pre-certification.</p>	<p>_____none_____</p>

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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
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.AlaskaCare.gov">www.AlaskaCare.gov</a> or by calling 1-855-784-8646.</p>	<p>Generic &amp; Brand Drugs</p>	<p>20% coinsurance (retail), subject to minimum and maximum limits.</p> <p><u>Retail minimum:</u> \$13 copay for up to 30-day supply; \$21 copay for 31-90-day supply.</p> <p><u>Retail maximum:</u> \$61 copay for up to 30-day supply; \$122 copay for 31-90-day supply.</p> <p><u>Mail order:</u> \$8 copayment (generic).  \$20 copayment (brand).</p>	<p>40% coinsurance (retail and mail order).</p>	<p>Covers up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescription).</p> <p><b>\$1,000</b> person/<b>\$2,000</b> 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).</p>

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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	<p>20% coinsurance (retail), subject to minimum and maximum limits.</p> <p><u>Retail minimum:</u> \$13 copay for up to 30-day supply; \$21 copay for 31-90-day supply.</p> <p><u>Retail maximum:</u> \$61 copay for up to 30-day supply; \$122 copay for 31-90-day supply.</p> <p><u>Mail order:</u> \$20 copayment.</p>	<p>40% coinsurance (retail and mail order).</p> <p>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.</p> <p>See your plan document for additional information about pre-certification. Call <b>1-855-784-8646</b> for pre-certification.</p>	<p>Covers up to a 30-day supply (retail prescription); 31-90 day supply (retail and mail order prescription).</p> <p><b>\$1,000</b> person / <b>\$2,000</b> 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).</p>

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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_____

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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_____

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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_____

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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	<p>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.</p> <p>Use of an out-of-network provider will result in 20% reduction in benefits.</p>	_____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_____

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	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.

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<p><b>If you need help recovering or have other special health needs</b></p>	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_____

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	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_____

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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

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