Coverage Period: 1/1/2025 -12/31/2025 Coverage for: Individual or Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> 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, call 1-800-809-9361 (TTY: 711) or visit us at https://www.premera.com/ak/SBC. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-809-9361 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No.	This <u>plan</u> does not have a <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-</u> <u>pocket limit?</u>	Not applicable.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network</u> <u>provider</u> ?	Yes. See Legacy and Dental Select medical network. For a list of in-network providers, see http://www.premera.com or call 1-800-809-9361.	You pay the least if you use a <u>provider</u> in our preferred network. You pay more if you use a <u>provider</u> in our non-preferred network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



Common	Services You May Need	What You Will Pay		Limitediana Francisco College Language
Medical Event		<u>Network Provider</u> (You will pay the least)	Out-Of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	No charge	No charge	none
If you visit a health care	Specialist visit	No charge	No charge	none
Provider's office or clinic	Preventive care / screening / immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	No charge	No charge	none
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	No charge	Prior authorization required for some outpatient imaging tests. The penalty is: 50% of the allowable charge up to a maximum of \$1,500 per occurrence.
If you need drugs to treat your illness or	Preferred generic drugs	No charge	No charge (retail) Not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
condition More information about prescription drug coverage is available at https://www.premera.com/documents/062281_202 5.pdf.	Preferred brand drugs	No charge	No charge (retail) Not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Non-preferred brand drugs	No charge	No charge (retail) Not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Specialty drugs	No charge	No charge	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	<u>Network Provider</u> (You will pay the least)	Out-Of-Network Provider (You will pay the most)	Information	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Prior authorization required for some services. The penalty is: 50% of the allowable charge up to a maximum of \$1,500 per occurrence.	
	Physician/surgeon fees	No charge	No charge	none	
	Emergency room care	No charge	No charge	none	
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	none	
	Urgent care	No charge	No charge	none	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of \$1,500 per occurrence.	
	Physician/surgeon fees	No charge	No charge	none	
If you need mental	Outpatient services	No charge	No charge	none	
health, behavioral health, or substance abuse services	Inpatient services	No charge	No charge	Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of \$1,500 per occurrence.	
	Office visits	No charge	No charge	none	
If you are pregnant	Childbirth/delivery professional services	No charge	No charge	Prior authorization is not required.	
	Childbirth/delivery facility services	No charge	No charge	Prior authorization is not required. However, you should notify the carrier of your admission for delivery as soon as reasonably possible.	
If you need help	Home health care	No charge	No charge	Limited to 130 visits per calendar year	

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	<u>Network Provider</u> (You will pay the least)	Out-Of-Network Provider (You will pay the most)	Information	
recovering or have other special health needs	Rehabilitation services	No charge	No charge	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of \$1,500 per occurrence.	
	Habilitation services	No charge	No charge	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of \$1,500 per occurrence.	
	Skilled nursing care	No charge	No charge	Limited to 60 days per calendar year. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of \$1,500 per occurrence.	
	Durable medical equipment	No charge	No charge	Prior authorization required to buy some medical equipment over \$750. The penalty is: 50% of the allowable charge up to a maximum of \$1,500 per occurrence.	
	Hospice service	No charge	No charge	Limited to 240 respite hours, limited to 10 inpatient days - 6 months overall lifetime benefit limit.	
	Children's eye exam	No charge	No charge	Limited to one exam per calendar year (under age 19).	
If your child needs dental or eye care	Children's glasses	No charge	No charge	Frames and lenses limited to 1 pair per calendar year.	
	Children's dental check-up	No charge	No charge	none	

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.)

Assisted fertility treatment

Dental care (Adult)

Private-duty nursing

Bariatric surgery

Hearing aids

Routine eye care (Adult)

Cosmetic surgery

Acupuncture

Long-term care

Weight loss programs

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

Abortion

Chiropractic care or other spinal manipulations

- Foot care
- Non-emergency care when traveling outside the U.S.

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: 1-907-269-7900 or 1-800-467-8725 for the state insurance department, or the insurer at 1-800-809-9361 or TTY 711. 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 <u>Grievance</u> and <u>Appeals</u> <u>Rights</u>: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a claim. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: your <u>plan</u> at 1-800-809-9361, or the state insurance department at 1-907-269-7900 or 1-800-467-8725.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

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 1-800-809-9361 or TTY 711.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-809-9361 or TTY 711.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-809-9361 or TTY 711.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-809-9361 or TTY 711.

-----To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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	None
■ Specialist copay	\$0
■ Hospital (facility) coinsurance	0%
■ Other <u>coinsurance</u>	0%

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	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$60	
The Total Peg would pay is	\$60	

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

■ The <u>plan's</u> overall <u>deductible</u>	None
■ Specialist <u>copay</u>	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

Total Example Cost

Durable medical equipment (*glucose meter*)

In this example, Joe would pay:			
Cost Sharing			
<u>Deductibles</u>	\$0		
<u>Copayments</u>	\$0		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions \$20			
The Total Joe would pay is	\$20		

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	None
■ Specialist <u>copay</u>	\$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

\$5.600

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

In this example, Mia would pay:

in this example, wild would pay.		
Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions		
The Total Mia would pay is	\$0	

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

Notice of availability and nondiscrimination 800-809-9361 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Vala'au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa'aopo'opo talafeagai ma auaunaga. ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.

ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة. براى خدمات كمك زباني رايگان و كمكها و خدمات امدادى مقتضى، تماس بگيريد.

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