This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.959trusts.com or by calling 1-800-478-4450.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,000 Person/$3,000 Family Does not apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. $1,000 if admitted to non-participating hospital. Dental benefits at $75 person; does not apply to diagnostic and preventive care.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	• $3,800 Person/$7,600 Family for medical PPO providers • $7,600 Person/$15,200 for medical non-PPO providers • $3,200 Person/$6,000 Family for prescriptions	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Coinsurance at a non-PPO facility, penalties for failure to obtain pre-certification for services. Non-emergent orthopedic surgery charges from a non-PPO provider. Amounts above the Hearing Aid Device maximum.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Medical – No annual limit. Dental - $2,000 for individuals over age 18.	Under ACA, medical annual limits no longer apply.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.959trusts.com or call 1-800-478-4450.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 an out-of-network **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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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 visits to treat an injury or illness	20%	40%	Coverage is limited to Usual, Customary and Reasonable fees.
	Specialist visit	20%	40%	Coverage is limited to Usual, Customary and Reasonable fees.
	Other practitioner office visit	20%	40%	Coverage is limited to Usual, Customary and Reasonable fees.
	Preventive care/screening/immunization	0%	0%	Pursuant to the Preventive Health Care Provision. For labs see schedule of benefits in the SPD (plan summary).
If you have a test	Diagnostic test (e.g., x-ray, blood work)	20%	40%	Coverage is limited to Usual, Customary and Reasonable fees.
	Imaging (e.g., CT/PET scans, MRIs)	20%	40%	Coverage is limited to Usual, Customary and Reasonable fees.

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.959trusts.com.	Generic drugs	20% retail / 20% or $20 mail-order	100%	34 day retail; 90 day mail-order
	Preferred brand drugs	35% retail / 35% or $50 mail-order	100%	34 day retail; 90 day mail-order
	Non-preferred brand drugs	50% retail / 50% or $100 mail-order	100%	34 day retail; 90 day mail-order
	Specialty drugs	$100 copay	100%	May only be filled at OptumRX's specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%	40%	
	Physician/surgeon fees	20%	40%	Non-emergent orthopedic surgery charges from a non-PPO provider are not covered.
If you need immediate medical attention	Emergency room services	20%	20%	Must be life threatening or true emergency.
	Emergency medical transportation	20%	40%	
	Urgent care	20%	40%	
If you have a hospital stay	Facility fee (e.g., hospital room)	20%	40%	Pre-certification is required.
	Physician/surgeon fee	20%	40%	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20%	40%	
	Mental/Behavioral health inpatient services	20%	40%	Pre-certification is required.
	Substance use disorder outpatient services	20%	40%	
	Substance use disorder inpatient services	20%	40%	Pre-certification is required.
If you are pregnant	Prenatal and postnatal care	20%	40%	Pregnancy is excluded for dependent adult and/or minor children.
	Delivery and all inpatient services	20%	40%	Pregnancy is excluded for dependent adult and/or minor children. Pre-certification is required.

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	20%	40% outside Anchorage	Plan pays 60% of PPO rate for non-PPO in Anchorage.
	Rehabilitation services	20%	40%	Maximum of 20 visits per year, including massage therapy. Limit 1 visit per day. Does not include services which are primarily educational, sports-related, or preventive in nature.
	Habilitation services	100%	100%	
	Skilled nursing care	20%	20%	The plan pays 80% of allowable covered expenses; up to 100 days.
	Durable medical equipment	20%	40%	Any accrual of charges for the rental of medical equipment that is in excess of the normal purchase price for that medical equipment is not a Covered Expense.
	Hospice service	20%	20%	
If your child needs dental or eye care	Eye exam	$10	Amount over $50	Frequency: 12 months
	Glasses	$25	Amount over $125 (single vision lenses and frames)	Includes lenses and frame Frequency: 12 months for lens; 24 months for frames.
	Dental check-up	20%	20%	Class I diagnostic and preventative.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Any service not specifically listed in the Summary Plan Description as a Covered Expense
- Bariatric surgery
- Charges above the usual, customary and reasonable fees
- Cosmetic procedures/surgery
- Dependency pregnancy
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care in ER
- Private-duty nursing
- Routine foot care
- Weight Loss program/treatment/surgery
- Work related illnesses or injuries

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care (limit of 10 office visits per calendar year)
- Hearing Aids (maximum benefit payable is $800 per device per ear during any 3 consecutive years)
- Services outside the United States (covered services are paid at non-participating rate)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protection that allows you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-478-4450. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Alaska Teamster-Employer Welfare Trust at 1-800-478-4450 or the Department of Labor's Employee Benefits Security Administration at 1-866-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-478-4450
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-478-4450
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-478-4450
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-478-4450

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,130
- **Patient pays** $2,410

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1000
Co-pays	$0
Co-insurance	$1,260
Limits or exclusions	$150
Total	**$2,410**

Note: Assumes using participating providers and generic prescriptions. Deductible includes both mother and baby. Healthy Mother Baby program is available; however, there is no requirement to participate. For information, please contact: Alaska Teamster-Employer Welfare Trust at 1-800-478-4450.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,470
- **Patient pays** $1,930

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1000
Co-pays	$0
Co-insurance	$850
Limits or exclusions	$80
Total	**$1,930**

Note: Assumes using participating providers and generic prescriptions. Medical Management program is available; however, there is no requirement to participate. For more information, please contact: Alaska Teamster-Employer Welfare Trust at 1-800-478-4450.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.