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 complete terms of coverage, please visit www.959trusts.com or call 1-800-478-4450. 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.959trusts.com or call 1-800-478-4450 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1000/Individual or $3,000/family	You must pay all of the costs from providers up to the deductible amount before this plan begins to pay for covered services you use.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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?	Yes. $1000 if admitted to a non-participating hospital. Dental benefits at $75 per 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.
What is the out-of-pocket limit for this plan?	$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 Prescription	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 costs.
What is not included in the out-of-pocket limit?	Coinsurance at a non-PPO facility, penalties for failure to obtain pre-authorization for services. Non-emergent orthopedic or podiatric surgery charges from a non-PPO provider.	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. For a list of preferred providers, see www.959trusts.com or call 1-800-478-4450	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.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

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
		Network Provider (You will pay the least)	Out-of-Network 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	Coverage is limited to Usual, Customary, and Reasonable fees.
	Specialist visit	20% coinsurance	40% coinsurance	Coverage is limited to Usual, Customary, and Reasonable fees.
	Preventive care/screening/ immunization	0% coinsurance	0% coinsurance	Pursuant to the Preventive Health Care Provision.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Coverage is limited to Usual, Customary, and Reasonable fees.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
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	Not Covered	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred brand drugs	35% retail/ 35% or $50 mail-order	Not Covered	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription).
	Non-preferred brand drugs	50% retail/ 50% or $100 mail-order	Not Covered	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription).
	Specialty drugs	$100 copay	Not Covered	If the value of a Participant's manufacturer-sponsored copay card or coupon for a specialty drug exceeds the amount of the Plan's general specialty Drug Copayment, the Copayment required under the Plan increases to match the amount of the copay card or coupon. The copay card or coupon is applied to the Participant's Copayment, and the Participant's out of pocket cost for the specialty drug fill is reduced to **$0**. The portion of the Copayment covered by the copay card or coupon does not apply to the out-of-pocket

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				maximums.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	50% penalty reduction applies and will not be applied towards the annual out-of-pocket limit (coinsurance).
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Non-emergent orthopedic or podiatric surgery charges from a non-PPO provider are not covered.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance of allowed amount	No benefits will be extended for emergency room care that is not related to an Emergency and/or could have been provided in a Physician's office, an outpatient clinic or urgent care center.
	Emergency medical transportation	20% coinsurance	20% coinsurance of allowed amount	
	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.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Pregnancy is excluded for dependent adult and/or minor children. Cost sharing does not apply to certain preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Plan pays 60% of PPO rate for non-PPO in Anchorage.
	Rehabilitation services	20% coinsurance	40% coinsurance	Rehabilitation services are limited to a maximum of 20 visits per year. Limit 1 visit per day. Does not include services which are primarily educational, sports-related, or preventive in nature.
	Habilitation services	100% coinsurance	100% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	
	Durable medical equipment	20% coinsurance	40% coinsurance	

For more information about limitations and exceptions, see plan or policy document at www.959trusts.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% coinsurance	20% coinsurance	
If your child needs dental or eye care	Children's eye exam	$10 copay	Amount over $50	Limited to one exam every 12 months.
	Children's glasses	$25 copay	Amount over $125 (Single vision lenses and frames)	Includes lenses and frame. Frequency: 12 months for lens; 24 months for frames.
	Children's dental check-up	20% coinsurance	20% coinsurance	Class I diagnostic and preventative.

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.)

- 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
- Maternity related services for dependent children
- Infertility treatment
- Non-PPO orthopedic and podiatric surgeries
- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care (limit of 15 office visits per calendar year)
- Hearing Aids (max. benefit payable is $800 per device per ear during any 3 consecutive years)
- Services outside the United States (covered services are paid at the non-participating rate)

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: Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

For more information about limitations and exceptions, see plan or policy document at www.959trusts.com.

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 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	$1000
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	$1000
Copayments	$0
Coinsurance	$2,360
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,360**

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

The plan's overall deductible	$1000
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	
Deductible	$1000
Copayments	$0
Coinsurance	$1,280
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,280**

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

The plan's overall deductible	$1000
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	
Deductible	$1000
Copayments	$0
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,180**

Note: These numbers assume the patient participates in the plan's wellness program, if necessary. If you do not participate in the plan's wellness program, and you have been selected to do so, you may have additional penalties. For more information about the wellness program, please contact the plan at 1-800-478-4450.