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, call 1-855-815-2323. 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.dol.gov/ebsa/healthreform or call 1-855-815-2323 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** per person / **$1,500** per family.	Generally, you must pay all of the costs from provider up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs and preventive care are 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: **$3,500** per person / **$7,000** per family. For Non-Preferred facility and physical therapy providers in the Municipality of Anchorage: **$7,000** per person / **$14,000** per family. Prescription drugs: **$3,000** per person / **$6,000** per family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, and health care this plan does not cover, ER and hospital penalties, and penalties for failure to receive preauthorization.	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. See www.aetna.com/docfind and select Aetna Choice® POS II (Open Access) network for a list of network providers.	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

Important Questions	Answers	Why This Matters:
	Teladoc Teladoc.com 1-800-835-2362. Coalition Health Center www.coalitionhealthcenter.com 907-450-3300. Transcarent-non-emergency surgery outside Alaska www.transcarent.com 844-249-8108, Alaska Regional Hospital, Surgery Center of Anchorage, Mat-Su Regional Hospital.	what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ 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	20% coinsurance	$30 copay for Wellness and Minor Care Program visits (waived if preventive). Copay and deductible waived at the Coalition Health Center. Copay and deductible waived for Teladoc visits. Massage therapy is limited to 10 visits per calendar year; service must be prescribed as part of a treatment plan and must be performed by a licensed professional acting within the scope of their license.
	Specialist visit			
	Preventive care/screening/ immunization	No charge Deductible does not apply.	No charge	Allowable charges for services at a non-PPO facility in Anchorage will be the rate of the Preferred Provider Hospital, or 50% of the billed charge if no rate is established. 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for preventive. 20% coinsurance for	No charge for preventive. 20% coinsurance for	Allowable charges for services at a non-PPO facility in Anchorage will be the rate of the

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)	
	Imaging (CT/PET scans, MRIs)	diagnostic	diagnostic / 40% coinsurance for non-PPO facility in Anchorage	Preferred Provider Hospital, or 50% of the billed charge if no rate is established.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://info.caremark.com/dig/druglist	Generic drugs	20% coinsurance (retail & mail order)	20% coinsurance	Covers up to a 30-day supply (retail) 31 – 90 day supply (mail order). **$50** penalty applies when generic is available and brand is purchased, does not apply to out-of-pocket limit. Maintenance medications must be purchased through mail order. Non-formulary drugs may not be covered without approval through the prior-authorization process. Insulin products and diabetic supplies purchased through the prescription drug benefit are subject to 20% coinsurance with a maximum copay of $100 per fill. You may obtain up to a 90-day supply per fill, via retail pharmacies or mail order.
	Preferred brand drugs	30% coinsurance (retail & mail order)	30% coinsurance	
	Non-preferred brand drugs	50% coinsurance (retail & mail order)	50% coinsurance	
	Specialty drugs	30% coinsurance preferred / 50% coinsurance non-preferred (retail & mail order)	Not covered	Prior authorization and step therapy is required. Covers up to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance for non-PPO facility in Anchorage. 20% coinsurance outside Anchorage	Allowable charges for facility services at a non-PPO facility in Anchorage will be the rate of the Preferred Provider Hospital, or 50% of the billed charge if no rate is established. Prior authorization required 50% reduction in benefits for non-compliance.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	$400 penalty for non-emergency services received in an ER, does not apply to the out-of-pocket limit.
	Emergency medical transportation			
	Urgent care			None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance for non-PPO facility in Anchorage.	$250 penalty applies to non-PPO facilities. Allowable charges for services at a non-PPO

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)	
			20% coinsurance outside Anchorage	facility in Anchorage will be the rate of the Preferred Provider Hospital, or 50% of the billed charge if no rate is established. Prior authorization required 50% reduction in benefits for non-compliance.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance for non-PPO facility in Anchorage. 20% coinsurance outside Anchorage.	Allowable charges for services at a non-PPO facility in Anchorage will be the rate of the Preferred Provider Hospital, or 50% of the billed charge if no rate is established.
	Inpatient services	20% coinsurance	40% coinsurance for non-PPO facility in Anchorage. 20% coinsurance outside Anchorage.	$250 penalty applies to non-PPO facilities. Allowable charges for services at a non-PPO facility in Anchorage will be the rate of the Preferred Provider Hospital, or 50% of the billed charge if no rate is established.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance for non-PPO facility in Anchorage. 20% coinsurance outside Anchorage.	$250 penalty applies to non-PPO facilities. Allowable charges for services at a non-PPO facility in Anchorage will be the rate of the Preferred Provider Hospital or 50% of the billed charge if no rate is established.
If you need help recovering or have other special health needs	Home health care	No charge deductible does not apply	No charge deductible does not apply	Limited to 130 visits per year. Patient must be home bound.
	Rehabilitation services	20% coinsurance	40% coinsurance for non-PPO provider in Anchorage. 20% coinsurance outside Anchorage.	No coverage for admissions or treatment primarily for rehabilitative care except as provided under the Skilled Nursing benefit. $250 penalty applies to non-PPO facility for inpatient services. Allowable charges for services at a non-PPO facility or physical therapy provider in Anchorage will be the rate of the Preferred Provider Hospital or Chugach Physical Therapy, or 50% of the billed charge if
	Habilitation services	20% coinsurance	40% coinsurance for non-PPO provider in Anchorage. 20% coinsurance outside	

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)	
			Anchorage.	no rate is established. . Deductible and coinsurance waived for virtual physical therapy through Sword.
	Skilled nursing care	20% coinsurance	20% coinsurance	120 day maximum limit
	Durable medical equipment	20% coinsurance	20% coinsurance	Requires physician's prescription
	Hospice services	20% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$10 copay/exam.	$10 copay/exam plus charges in excess of $45	Limited to one exam every 12 months from the last date of service.
	Children's glasses	$25 copay plus charges in excess of $120 for frames	$25 copay plus charges in excess of $45 for single vision lenses and charges in excess of $47 for frames	Lenses limited to one pair every 12 months from the date of last services. Frames limited to one pair every 24 months from date of last service.
	Children's dental check-up	20% coinsurance	20% coinsurance	Dental check-ups limited to one exam in any period of 6 consecutive months.

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.)

- Alternative care (naturopath, nutritionist)
- Cosmetic surgery (unless performed for correction of functional disorders or as a result of an accidental injury)
- Infertility treatment
- Long-term care
- Routine foot care
- Sex transformation
- Gene and cellular therapies
- Marital, sex, or family counseling
- Weight loss programs
- Work related injuries

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Diabetic Education
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult) See www.vsp.com

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Trust Administration Office at 1-855-815-2323.

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 the 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 1-855-815-2323.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-815-2323.

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	$500
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**2,960$**

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

The plan's overall deductible	$500
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	$500
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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