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 1-800-331-6158. 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 1-800-331-6158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250** per person/**$650** 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.** Preventive care, outpatient prescription drug charges, 2nd and 3rd surgical opinions, Teladoc visits, CHC visits, Transcarent surgery, audio, dental and vision benefit services 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 Preferred Providers: **$1,200** per person/**$4,000** per family, Medical Non-Preferred Facilities: **$2,400** per person/**$8,000** per family. Prescription Drug: **$800** per person/**$3,000** per family Specialty Prescription Drug: $2,000 per person. The family out-of-pocket limit for medical and prescription combined shall not exceed the federally mandated out-of-pocket limits.	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, health care this plan does not cover, the deductible, prescription drugs purchased at non-participating pharmacies, and penalty for failure to obtain preauthorization.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
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. The preferred hospital in the Municipality of Anchorage is Alaska Regional, www.alaskaregional.com or the Surgery Center of Anchorage. For Caremark's preferred pharmacies, see www.caremark.com. To locate a preferred vision provider see www.vsp.com. For Teladoc visit www.Teladoc.com or 800-835-2362. For Transcarent visit www.transcarent.com or call 844-249-8108.	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 (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	Deductible and copay waived for Teladoc visits. All services must be medically necessary. $10 copay for Minor Care services at Coalition Health Center. Physical therapy and chiropractic care each limited to 24 visits per calendar year. Acupuncture limited to 12 visits per year.
	Specialist visit			
	Preventive care/screening/ immunization	No charge Deductible does not apply.	No Charge/ 40% coinsurance for non-PPO hospital	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance / 40% coinsurance for Non-PPO hospital	All services must be medically necessary. Allowable charges for outpatient services at a non-preferred hospital in the Municipality of Anchorage will be the rate of the Preferred Provider Hospital, or 50% of the billed charges if no rate is established.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to	Generic drugs	No charge	40% coinsurance	Covers up to a 30-day supply for a retail

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)	
treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Preferred brand drugs	Retail: 30% coinsurance; Mail Order: 20% coinsurance	40% coinsurance	prescription and 31-90 day supply for a mail order prescription. Covers 90-day supply of non-specialty prescriptions at retail pharmacies. Charges for prescription drugs obtained at non-participating pharmacies do not apply to the annual prescription drug out-of-pocket limit
	Non-preferred brand drugs	50% coinsurance	40% coinsurance	
	Specialty drugs	10% coinsurance up to $150 / prescription;	40% coinsurance	Preauthorization is required. Limited to 30-day supply. Step-therapy required for certain medications. Use of CVS Caremark Specialty Pharmacy required for specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	All services must be medically necessary. Allowable charges for outpatient services at a non-preferred hospital in the Municipality of Anchorage will be the rate of the Preferred Provider Hospital, or 50% of the billed charges if no rate is established.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	$500 emergency room penalty for non-emergency services between 8am-8pm.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. The lesser of 30% coinsurance or the reimbursement percentage applies if hospital stay is not preauthorized, up to a maximum penalty of $500. Allowable charges for services at a non-preferred hospital in the Municipality of Anchorage will be the rate of the Preferred Provider Hospital, or 50% of the billed charges if no rate is established.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need mental	Outpatient services	20% coinsurance	20% coinsurance	

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)	
health, behavioral health, or substance abuse services	Inpatient services	20% coinsurance	40% coinsurance	Marriage and family counseling are not covered. Confinement for custodial care is not covered. The lesser of 30% coinsurance or the reimbursement percentage applies if hospital stay is not preauthorized, up to a maximum penalty of $500. Allowable charges for services at a non-preferred hospital in the Municipality of Anchorage will be the rate of a PPO Hospital, or 50% of the billed charges if no rate is established. Services must be provided by a state-licensed health provider.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost-sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	No less than 48 hours of inpatient care for mother and newborn following a vaginal delivery or 96 hours following a cesarean section, unless the mother and attending physician agree to an earlier discharge. The lesser of 30% coinsurance or the reimbursement percentage applies if the inpatient stay is not preauthorized beyond 48/96 hours, up to a maximum penalty of $500. Allowable charges for services at a non-PPO hospital in the Municipality of Anchorage will be the rate of a PPO Hospital, or 50% of the billed charges if no rate is established. Newborn of a dependent child not covered.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Services must be in place of a covered confinement in a hospital or skilled nursing facility. Custodial care is not covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	All services must be medically necessary. Preauthorization is required for any inpatient stays. The lesser of 30% coinsurance or the
	Habilitation services	20% coinsurance	40% coinsurance	

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)	
				reimbursement percentage applies if inpatient stay is not preauthorized, up to a maximum penalty of $500. Allowable charges for services at a non-PPO hospital in the Municipality of Anchorage will be the rate of a PPO Hospital, or 50% of the billed charges if no rate is established.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled Nursing or Extended Care limited to 90 days. Preauthorization is required for any inpatient stays. The lesser of 30% coinsurance or the reimbursement percentage applies if inpatient stay is not preauthorized, up to a maximum penalty of $500. Allowable charges for services at a non-PPO hospital in the Municipality of Anchorage will be the rate of a PPO Hospital, or 50% of the billed charges if no rate is established.
	Durable medical equipment	20% coinsurance	20% coinsurance	None.
	Hospice services	20% coinsurance	20% coinsurance	Services must be in place of a covered confinement in a hospital or skilled nursing facility. Custodial care is not covered.
If your child needs dental or eye care	Children's eye exam	No charge	Excess of $50	Your child is only covered if you have elected dental, vision and audio coverage for your dependent and paid the appropriate premiums. Vision coverage is provided through VSP. $50 dental deductible waived for preventative dental services.
	Children's glasses	Up to $120 frames Up to $200 for contact lenses	Charges over the excess of $120 for frames & $90 for lenses Up to $200 for contact lenses	
	Children's dental check-up	$50 annual deductible $150 family deductible no cost thereafter for preventive and diagnostic services	$50 annual deductible $150 family deductible no cost thereafter for preventive and diagnostic services.	

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.)

- Cosmetic Surgery (except to correct function disorder)
- Custodial care in a psychiatric hospital or alcoholism treatment facility
- Domestic Partners
- Marriage and family counseling
- Newborn charges of a dependent child
- Work related injuries

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

- Acupuncture (limited to 12 visits per year)
- Bariatric Surgery
- Chiropractic Care (limited to 24 visits per year)
- Dental care (adult) (if you elected coverage and paid premiums)
- Hearing aids
- Infertility Treatment
- Long-term care (must be medically necessary level of care)
- Non-emergency care when traveling outside the U.S. if hospital is accredited by the Joint Commission International.
- Private duty nursing
- Routine eye care (adult) (if you elected coverage and paid premiums)
- Routine foot care
- Weight loss programs

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 1-800-331-6158.

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 1-800-331-6158.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-331-6158.

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	$250
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	$250
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,510**

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

The plan's overall deductible	$250
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	$250
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,170**

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

The plan's overall deductible	$250
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	$250
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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