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, option 0. 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?	**$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?	Yes. $25 per person / $75 per family for dental benefits. There are no other specific deductibles.	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?	Medical: **$3,500** per person / **$10,500** per family. Prescription Drugs: **$4,500** per person / **$5,600** 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-billing charges, health care this plan doesn't cover, the deductible, expenses in excess of usual, customary and reasonable (UCR), penalties for failing to follow the preadmission certification requirements, prescription drugs, vision and dental benefits.	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 preferred providers. Alaska Regional Hospital is the preferred hospital in Anchorage. Transcarent medical for certain	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

Important Questions	Answers	Why This Matters:
	surgical services www.transcarent.com. For Teladoc visit Teladoc.com or call 1-800-835-2362.	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 of the PPO allowance	20% coinsurance of the usual, customary and reasonable (UCR) charge	Coinsurance and deductible waived for Teladoc visits. Preventive benefits are HHS and CDC recommendations. Massage therapy is not covered. Acupuncture, chiropractic and naturopathic visits limited to 18 visits per year.
	Specialist visit			
	Preventive care/screening/ immunization	No charge Deductible does not apply.	Charges in excess of the UCR amount	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 of the PPO allowance	20% coinsurance of the UCR charge	No charge if preadmission testing required for surgery and surgery is completed within 7 days.
	Imaging (CT/PET scans, MRIs)			
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	10% coinsurance Retail / $5 min; 10% coinsurance Mail / $15 min.	30% coinsurance ($100 maximum) Maximum 30 day supply. No out-of-network coverage for Specialty drugs.	Retail is limited to 30-day supply Mail is limited to 90-day supply. Specialty drugs limited to 30-day supply. Prescriptions purchased at a non-preferred pharmacy are limited to a 30-day supply. Full payment at time of purchase is required at non-preferred pharmacies; you must submit a claim form to request reimbursement.
	Preferred brand drugs	20% coinsurance Retail / $100 max; 20% coinsurance Mail / $300 max.		
	Non-preferred brand drugs	30% coinsurance Retail / $100 max;		

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)	
		30% coinsurance Mail / $300 max.		
	Specialty drugs	Same as generic/brand benefit		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	20% coinsurance applies to surgeries performed in a doctor's office. 50% penalty for failure to obtain precertification or 2nd surgical opinion when required.
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	Emergency room care	20% coinsurance of the PPO allowance	20% coinsurance of the UCR charge	None.
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance of the PPO allowance	20% coinsurance of the UCR allowance	Preadmission certification required. If no precertification is obtained, the reimbursement rate will be 50%. All in-patient admissions and related services and supplies limited to 100 days per calendar year.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance of the PPO allowance	20% coinsurance of the UCR charge	None.
	Inpatient services	20% coinsurance of the PPO allowance	20% coinsurance of the UCR charge	Preadmission certification required. If no precertification is obtained, the reimbursement rate will be 50%. All in-patient admissions and related services and supplies limited to 100 days per calendar year.
If you are pregnant	Office visits	20% coinsurance of the PPO allowance	20% coinsurance of the UCR charge	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. No coverage for dependent child or child of dependent child. No facility charge for use of birthing center. Midwives' must work for the birthing center in
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

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)	
				order to be covered
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Limited to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance of the PPO allowance	20% coinsurance of the UCR charge	Limited to 100 days per calendar year. Physical, occupational and speech therapy limited to 40 visits per year. Formal treatment plan required after 25th visit.
	Habilitation services	20% coinsurance of the PPO allowance	20% coinsurance of the UCR charge	Benefits limited to the treatment of a mental health disorder or congenital anomaly. Formal treatment plan required after 25th visit.
	Skilled nursing care	No Charge	No Charge	Precertification required, if not obtained the reimbursement rate is 50%. Maximum of 100 days per calendar year including all related services and supplies.
	Durable medical equipment	20% coinsurance of the PPO allowance	20% coinsurance of the UCR charge	Rental or purchase of medically necessary equipment. Cost of rental covered up to purchase price.
	Hospice services	20% coinsurance of the PPO allowance	20% coinsurance of the UCR charge	Limited to 30 days inpatient or $3,000 outpatient.
If your child needs dental or eye care	Children's eye exam	10% coinsurance plus costs in excess of $115.		
	Children's glasses	Lens: 10% of UCR charges (single vision) Frames: 10% and costs in excess of $115		Frame benefit limited to once every two calendar years. Lens benefit limited to once every calendar year. Benefit applicable to children up to age 18. Older children subject to dollar maximums for lenses.
	Children's dental check-up	Up to 20% of UCR charges.	Up to 20% of UCR charges.	Benefit applicable to children up to age 18. Older children subject to annual maximum of $2,000..

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.)

- Bariatric Surgery
- Benefits when Medicare is or could be primary (This exclusion applies if you are eligible to enroll in Medicare, but fail to do so)
- Cosmetic Surgery (except to correct function disorder)
- Hearing Aids
- Infertility treatment
- Injury or Illness for which a third-party may be responsible
- Massage Therapy
- Pregnancy for a dependent child
- Routine foot care
- Weight loss programs
- Work related injury or illness

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

- Acupuncture
- Chiropractic Care
- Dental Care (Adult)
- Inpatient hospital or skilled nursing care limited to 100 days per calendar year
- Long-term care limited to 100 days per calendar year
- Non-emergency care when traveling outside the U.S. (care must be medically necessary and considered standard care in the U.S.)
- Private duty nursing limited to 100 days per calendar year
- Routine eye care (Adult)

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	$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	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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	**$2,000**

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