

 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, go to [www.alaskaplan.org](http://www.alaskaplan.org) or call 844-427-8501. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 844-427-8501 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">Coalition/PPO Provider or Any Provider Outside of Anchorage:</a> \$750 person / \$1,500 family <a href="#">Non-PPO (Non-Coalition) in Anchorage:</a> \$1,500 person / \$3,000 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , routine physicals, preadmission tests, 2nd surgical opinion, home health care, and confinement in a skilled nursing facility are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket</a> limit for this <a href="#">plan</a>?</b>	Medical: For <a href="#">Coalition/PPO Provider or Any Provider Outside of Anchorage:</a> \$4,000 person / \$8,000 family; <a href="#">Non-PPO (Non-Coalition) in Anchorage:</a> \$11,250 person / \$22,500 family. <a href="#">Prescription Drugs:</a> \$2,350 person / \$4,700 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket</a> limit?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties, Non-PPO <a href="#">copays</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.aetna.com">www.aetna.com</a> or call 1-844-427-8501 for a list of <a href="#">PPO providers</a> .	This <a href="#">plan</a> uses a <a href="#">PPO provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's PPO <a href="#">network</a> . You will pay the most if you use a <a href="#">Non-PPO provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">PPO provider</a> might use a <a href="#">Non-PPO provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> 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
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> for Wellness and Minor Care Program visits. \$0 <a href="#">copay</a> at the Coalition Health Center. Massage therapy is not covered.
	<a href="#">Specialist</a> visit	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	No charge; <a href="#">deductible</a> does not apply	<a href="#">Preventive care</a> based on government guidelines. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your provider if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	40% <a href="#">coinsurance</a>	Non-hospital 40% <a href="#">coinsurance</a> ; Hospital Outpatient 50% <a href="#">coinsurance</a> for Non-PPO facility in the Municipality of Anchorage	The Allowed amount for services at a Non-PPO facility in Anchorage will be the rate of the <a href="#">PPO Provider</a> Hospital.
	Imaging (CT/PET scans, MRIs)			
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs (Tier 1)	Retail: 50% <a href="#">coinsurance</a> with \$5 minimum. Mail order: 50% <a href="#">coinsurance</a> with \$10 minimum.	Retail: 50% <a href="#">coinsurance</a> with \$5 minimum. Mail order: 50% <a href="#">coinsurance</a> with \$10 minimum.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Brand drugs when a generic is available the plan pays 60% of the cost of the generic equivalent; you pay full cost of the difference between brand and generic. Compound medications in excess of \$500 require <a href="#">preauthorization</a> . <a href="#">Specialty drugs</a> are limited to one fill (30-day supply) per month and require <a href="#">preauthorization</a> .
	Brand drugs (Tier 2)			
	<a href="#">Specialty drugs</a> (Tier 3)	<a href="#">Deductible</a> does not apply.	<a href="#">Deductible</a> does not apply.	
	Diabetic oral medications, Insulin and supplies	Retail \$5 <a href="#">copay</a> Mail \$10 <a href="#">copay</a>	Retail \$5 <a href="#">copay</a> Mail \$10 <a href="#">copay</a>	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.alaskaplan.org](http://www.alaskaplan.org)]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	Ambulatory surgery center: 40% <a href="#">coinsurance</a> Outpatient Hospital: 50% <a href="#">coinsurance</a> for Non-PPO facility in the Municipality of Anchorage.	<a href="#">Preauthorization</a> may be required.  Outpatient Hospital: The Allowed amount for services at a Non-PPO facility in Anchorage will be the rate of the <a href="#">PPO Provider</a> Hospital.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> plus 40% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> plus 40% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Covered only to the nearest hospital equipped to treat your condition.
	<a href="#">Urgent care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 <a href="#">copay</a> plus 40% <a href="#">coinsurance</a>	\$350 <a href="#">copay</a> plus 40% <a href="#">coinsurance</a> / 50% <a href="#">coinsurance</a> for Non-PPO facility in the Municipality of Anchorage.	<a href="#">Preauthorization</a> is required. The Allowed amount for services at a Non-PPO facility in Anchorage will be the rate of the <a href="#">PPO Provider</a> Hospital. <a href="#">Copay</a> is waived after 4 or more stays/ person/ calendar year.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required.
	Inpatient services	\$350 <a href="#">copay</a> plus 40% <a href="#">coinsurance</a>	\$350 <a href="#">copay</a> plus 40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.alaskaplan.org](http://www.alaskaplan.org)]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you are pregnant	Office visits	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> or <a href="#">copay</a> may apply.
	Childbirth/delivery professional services  Childbirth/delivery facility services	  \$350 <a href="#">copay</a> plus 40% <a href="#">coinsurance</a>	  \$350 <a href="#">copay</a> plus 40% <a href="#">coinsurance</a> / 50% <a href="#">coinsurance</a> for Non-PPO facility in the Municipality of Anchorage.	No coverage provided for pregnancy of a dependent child other than preventive care. Inpatient benefits may be denied if the prior authorization program is not followed. <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). The Allowed amount for services at a Non-PPO facility in Anchorage will be the rate of the <a href="#">PPO Provider</a> Hospital.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge; <a href="#">deductible</a> does not apply	No charge; <a href="#">deductible</a> does not apply.	Limited to up to 100 visits per calendar year.
	<a href="#">Rehabilitation services</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Allowed amount for services at a Non-PPO facility in Anchorage will be the rate of the <a href="#">PPO Provider</a> .
	<a href="#">Habilitation services</a>	\$10 <a href="#">copay</a> / day	\$10 <a href="#">copay</a> / day	Limited to 30 hour/ week maximum benefit. <a href="#">Preauthorization</a> may be required.
	<a href="#">Skilled nursing care</a>	No charge; <a href="#">deductible</a> does not apply	No charge; <a href="#">deductible</a> does not apply.	Limited to up to 100 days per period of confinement. <a href="#">Preauthorization</a> may be required.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Must be terminally ill with life expectancy of 12 months or less.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

[\* For more information about limitations and exceptions, see the plan or policy document at [www.alaskaplan.org](http://www.alaskaplan.org)]

## 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](#).)

- Acupuncture (except when used as an anesthetic agent for covered surgery)
- Cosmetic Surgery (unless performed for correction of functional disorders or as a result of an accidental injury)
- Massage therapy
- Infertility treatment
- Long-term care
- Pregnancy for a dependent child or child of a dependent child.
- Private-duty nursing
- Weight loss programs

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

- Chiropractic Care
- Dental Care (Employee only)
- Hearing Aids
- Glasses (Employee only)
- Routine eye care (Employee only)
- Non-emergency care when traveling outside the U.S. which is medically necessary and standard of care in the U.S.
- Routine foot care
- Surgery to treat morbid obesity

**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: U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-3372 or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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: U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-3372 or [www.dol.gov/ebsa/healthreform](http://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.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-331-6158.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-331-6158.

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

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## 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 PPO pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine PPO care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist coinsurance</a>	40%	■ <a href="#">Specialist coinsurance</a>	40%	■ <a href="#">Specialist coinsurance</a>	40%
■ Hospital (facility) <a href="#">copay</a> and <a href="#">coinsurance</a>	\$350+40%	■ Hospital (facility) <a href="#">copay</a> and <a href="#">coinsurance</a>	\$350+40%	■ Hospital (facility) <a href="#">copay</a> and <a href="#">coinsurance</a>	\$350+40%
■ Other <a href="#">coinsurance</a>	40%	■ Other <a href="#">coinsurance</a>	40%	■ Other <a href="#">coinsurance</a>	40%
<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Specialist</a> office visits (prenatal care)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (ultrasounds and blood work)  <a href="#">Specialist</a> visit (anesthesia)</p>		<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Primary care physician</a> office visits (including disease education)  <a href="#">Diagnostic tests</a> (blood work)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (glucose meter)</p>		<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Emergency room care</a> (including medical supplies)  <a href="#">Diagnostic test</a> (x-ray)  <a href="#">Durable medical equipment</a> (crutches)  <a href="#">Rehabilitation services</a> (physical therapy)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$750	<a href="#">Deductibles</a>	\$750	<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$400	<a href="#">Copayments</a>	\$200	<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$2,900	<a href="#">Coinsurance</a>	\$100	<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,110</b>	<b>The total Joe would pay is</b>	<b>\$1,070</b>	<b>The total Mia would pay is</b>	<b>\$1,650</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.