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 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 https://www.healthcare.gov/sbc-glossary or call 844-427-8501 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Coalition/PPO Provider or Any Provider Outside of Anchorage: **$250** person / **$500** family; Non-PPO (Non-Coalition) in Anchorage: **$500** person / **$1,000** family	Generally, you must pay all of the costs from providers 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, routine physicals, preadmission tests, 2nd surgical opinion, home health care, and confinement in a skilled nursing facility 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: For Coalition/PPO Provider or Any Provider Outside of Anchorage: **$3,000** person / **$6,000** family; Non-PPO (Non-Coalition) in Anchorage: **$8,750** person / **$16,500** family. Prescription Drugs: **$2,350** person / **$4,700** 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, penalties, Non-PPO copays and health care this plan doesn't cover.	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 or call 1-844-427-8501 for a list of PPO providers.	This plan uses a PPO provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use a Non-PPO 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 PPO provider might use a Non-PPO 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
		PPO Provider (You will pay the least)	Non-PPO 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	$20 copay for Wellness and Minor Care Program visits. $0 copay at the Coalition Health Center. Massage therapy is not covered.
	Specialist visit	20% coinsurance	20% coinsurance	
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	Preventive care based on government guidelines. 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	Non-hospital 20% coinsurance; Hospital Outpatient 30% coinsurance 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 PPO Provider Hospital.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs (Tier 1)	Retail: 30% coinsurance with $5 minimum. Mail order: 30% coinsurance with $10 minimum. Deductible does not apply.	Retail: 30% coinsurance with $5 minimum. Mail order: 30% coinsurance with $10 minimum. Deductible does not apply.	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 preauthorization. Specialty drugs are limited to one fill (30-day supply) per month and require preauthorization.
	Brand drugs (Tier 2)			
	Specialty drugs (Tier 3)			
	Diabetic oral medications, Insulin and supplies	Retail: $5 copay Mail order: $10 copay	Retail: $5 copay Mail order: $10 copay	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Ambulatory surgery center: 20% coinsurance	Preauthorization may be required.
			Outpatient Hospital: 30% coinsurance for Non-PPO facility in the Municipality of Anchorage.	Outpatient Hospital: The allowed amount for services at a Non-PPO facility in Anchorage will be the rate of the PPO Provider Hospital.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at 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 need immediate medical attention	Emergency room care	$100 copay plus 20% coinsurance	$100 copay plus 20% coinsurance	$100 copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Covered only to the nearest hospital equipped to treat your condition.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay plus 20% coinsurance	$350 copay plus 20% coinsurance / 30% coinsurance for Non-PPO facility in the Municipality of Anchorage.	Preauthorization is required. The allowed amount for services at a Non-PPO facility in Anchorage will be the rate of the PPO Provider Hospital. Copay is waived after 4 or more stays/ person/ calendar year.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	Preauthorization may be required.
	Inpatient services	$350 copay plus 20% coinsurance	$350 copay plus 20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or copay may apply.
	Childbirth/delivery professional services	$350 copay plus 20% coinsurance	$350 copay plus 20% coinsurance / 30% coinsurance 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. Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment or coinsurance 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 PPO Provider Hospital.
	Childbirth/delivery facility services			

[* For more information about limitations and exceptions, see the plan or policy document at 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 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 up to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance	20% coinsurance	Allowed amount for services at a Non-PPO facility in Anchorage will be the rate of the PPO Provider.
	Habilitation services	$10 copay / day	$10 copay / day	Limited to 30 hour/ week maximum benefit. Preauthorization may be required.
	Skilled nursing care	No charge; deductible does not apply	No charge; deductible does not apply.	Limited to up to 100 days per period of confinement. Preauthorization may be required.
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	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

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 (exept 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)
- Private-duty nursing
- Massage therapy
- Infertility treatment
- Long-term care
- Pregnancy for a dependent child or child of a dependent child.
- Weight loss programs
- Routine eye care (Employee Only) (may be provided separately)
- Dental care (Employee Only) (may be provided separately)
- Dental care (Child)

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

- Chiropractic Care (limited to 1 visit/day)
- Hearing Aids ($3,000 limit / every 3 calendar years)
- 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 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 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. 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 Value Standards, 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.

[* For more information about limitations and exceptions, see the plan or policy document at www.alaskaplan.org]

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, kwiijigo holne' 1-800-331-6158.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-331-6158 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-331-6158.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-331-6158.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-331-6158.

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

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[* For more information about limitations and exceptions, see the plan or policy document at www.alaskaplan.org]

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) copay and coinsurance	$350 copay + 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	$400
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,110**

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) copay and coinsurance	$350 copay + 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	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$670**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) copay and coinsurance	$350 copay + 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	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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