




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](http://www.dol.gov/ebsa/healthreform) or call 1-855-815-2323 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$1,500 per person / \$4,500 per family.	Generally, you must pay all of the costs from <a href="#">provider</a> 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="#">Prescription drugs</a> and <a href="#">preventive care</a> 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</a> services without cost sharing 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 limit</a> for this <a href="#">plan</a>?</b>	Medical: \$3,500 per person / \$7,000 per family. For Non-Preferred facility and physical therapy providers in the Municipality of Anchorage: \$8,000 per person / \$16,000 per family. Prescription: \$3,000 per person / \$6,000 per 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.
	Premiums, balance billed charges, and health care this <a href="#">plan</a> 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 <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/docfind">www.aetna.com/docfind</a> and select Aetna Choice® POS II (Open Access) network for a list of <a href="#">network providers</a> . Teladoc Teladoc.com 1-800-835-2362.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network 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="#">network provider</a> might use an

Important Questions	Answers	Why This Matters:
	Coalition Health Center <a href="http://www.coalitionhealthcenter.com">www.coalitionhealthcenter.com</a> 907-450-3300. Transcarent non-emergency surgery outside Alaska <a href="http://www.transcarent.com">www.transcarent.com</a> 844-249-8108. Alaska Regional Hospital, Surgery Center of Anchorage, Mat-Su Regional Hospital.	<a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> for Wellness and Minor Care Program visits (waived if preventive). <a href="#">Copay and deductible</a> waived at the Coalition Health Center. <a href="#">Copay</a> and <a href="#">deductible</a> 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.
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible does not apply.</a>	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. 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 have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge for preventive. 30% <a href="#">coinsurance</a> for diagnostic	No charge for preventive. 30% <a href="#">coinsurance</a> for diagnostic / 40%	Allowable charges for services at a non-PPO facility in Anchorage will be the rate of the Preferred Provider Hospital, or 50% of the
	Imaging (CT/PET scans,			

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)	
	MRIs)		<a href="#">coinsurance</a> for non-PPO facility in Anchorage	billed charge if no rate is established.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://info.caremark.com/dig/druglist">prescription drug coverage</a> is available at <a href="https://info.caremark.com/dig/druglist">https://info.caremark.com/dig/druglist</a>	Generic drugs	20% <a href="#">coinsurance</a> (retail & mail order)	20% <a href="#">coinsurance</a>	Covers up to a 30-day supply (retail) 31 – 90 day supply (mail order). <b>\$50</b> penalty applies when generic is available and brand is purchased, does not apply to out-of-pocket maximum. Maintenance medications must be purchased through mail order. Non-formulary drugs may not be covered without approval through the prior-authorization process.
	Preferred brand drugs	30% <a href="#">coinsurance</a> (retail & mail order)	30% <a href="#">coinsurance</a>	
	Non-preferred brand drugs	50% <a href="#">coinsurance</a> (retail & mail order)	50% <a href="#">coinsurance</a>	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.
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a> preferred / 50% <a href="#">coinsurance</a> non-preferred (retail & mail order)	Not covered	Prior authorization and step therapy is required. Covers up to 30-day supply.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> for non-PPO facility in Anchorage. 30% <a href="#">coinsurance</a> 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	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a> <a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$400 penalty for non-emergency services received in an ER, does not apply to the <u>out-of-pocket limit</u> .

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)	
	<a href="#">Urgent care</a>			None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> for non-PPO facility in Anchorage. 30% <a href="#">coinsurance</a> 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. Prior authorization required 50% reduction in benefits for non-compliance.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <a href="#">coinsurance</a>	40% coinsurance for non-PPO facility in Anchorage. 30% <a href="#">coinsurance</a> 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	30% <a href="#">coinsurance</a>	40% coinsurance for non-PPO facility in Anchorage. 30% <a href="#">coinsurance</a> 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	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Cost sharing does not apply for preventive services. Depending on the type of service, <a href="#">coinsurance</a> may apply. Pregnancy preventive care and childbirth is covered for dependent daughter.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> for non-PPO facility in Anchorage. 30% <a href="#">coinsurance</a> 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. pregnancy preventive care and childbirth is covered for dependent daughter.
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 130 visits per year. Patient must be home bound.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	40% coinsurance for	No coverage for admissions or treatment

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)	
			non-PPO provider in Anchorage. 30% <a href="#">coinsurance</a> outside Anchorage.	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 in Anchorage will be the rate of the Preferred Provider Hospital or 50% of the billed charge if no rate is established. Deductible and coinsurance waived for virtual physical therapy through Sword
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> for non-PPO provider in Anchorage. 30% <a href="#">coinsurance</a> outside Anchorage.	
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	120 day maximum limit
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Requires physician's prescription
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If your child needs dental or eye care	Children's eye exam	\$10 <a href="#">copay</a> /exam.	\$10 <a href="#">copay</a> /exam plus charges in excess of \$45	Limited to one exam every 12 months from the last date of service.
	Children's glasses	Not Covered	Not covered	None
	Children's dental check-up	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Dental check-ups limited to one exam in any period of 6 consecutive months.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Alternative care (naturopath, nutritionist)</li> <li>Cosmetic surgery (unless performed for correction of functional disorders or as a result of an accidental injury)</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Marital, sexual, or family counseling</li> <li>Routine foot care</li> <li>Sex transformation</li> <li>Gene and cellular therapies</li> </ul>	<ul style="list-style-type: none"> <li>Vision Hardware</li> <li>Weight loss programs</li> <li>Work related injuries</li> </ul>	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Diabetic education</li> <li>Hearing Aids</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private duty nursing</li> <li>Routine eye care (Adult) See <a href="http://www.vsp.com">www.vsp.com</a></li> </ul>	

**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](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 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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,560</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,720</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$400
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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