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, log into your account at www.aseahealth.org or call 1.866.553.8206. 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 in your Plan booklet, or request a copy by calling 1.866.553.8206.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $0 | |
| Are there services covered before you meet your deductible? | This plan has no deductible for covered medical services. | See the chart starting on page 2 for your costs for services this plan covers. |
| Are there other deductibles for specific services? | For dental services, the deductible is $25/person and $75/family. | 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? | This plan has no out-of-pocket limit for covered medical services. | See the chart starting on page 2 for your costs for services this plan covers. . |
| What is not included in the out-of-pocket limit? | This plan has no out-of-pocket limit for covered medical services. | See the chart starting on page 2 for your costs for services this plan covers. |
| Will you pay less if you use a network provider? | Yes. Medical network providers in the Municipality of Anchorage are: Alaska Regional Hospital, Surgery Center of Anchorage, ACENT Ear Nose & Throat, Geneva Woods Birth Center, Chugach Physical Therapy, Ascension Physical Therapy, Alaska Fracture & Orthopedic and Alaska Hand Rehabilitation. In the Mat-Su Borough: Mat Su Regional Medical Center. For all other areas, the Aetna PPO Network. | This plan uses provider networks. 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. |

| | | |
|---|---|---|
| | For a list of participating providers, see www.aetna.com. For a list of participating pharmacy providers, see www.caremark.com. | |
| Do you need a referral to see a specialist? | No | You can see the specialist you choose without permission from this plan. |

 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 office visits to treat an injury or illness | 80% coinsurance | 80% coinsurance | None |
| | Specialist visit | 80% coinsurance | 80% coinsurance | None |
| | Preventive care/screening/ immunizations | No charge for recommended services under PPACA; 80% coinsurance for all other preventive services | No charge for recommended services under PPACA; 80% coinsurance for all other preventive services | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. And then check what your plan will pay cover. |
| If you have a test | Diagnostic test (x-ray, blood work) | 80% coinsurance | 80% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 80% coinsurance | 80% coinsurance | May require preauthorization |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.caremark.com | Generic drugs (retail & mail order) | 80% coinsurance per prescription | 80% coinsurance per prescription | Up to a 90-day supply. |
| | Preferred brand drugs (retail & mail order) | 80% coinsurance per prescription | 80% coinsurance per prescription | |
| | Non-preferred brand drugs (retail & mail order) | 80% coinsurance per prescription | 80% coinsurance per prescription | |
| | Specialty drugs | 80% coinsurance | 80% coinsurance | Up to a 30-day supply; requires preauthorization |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 80% coinsurance | 80% coinsurance | May require preauthorization. If you don't get preauthorization, benefits could be reduced. |
| | Physician/surgeon fees | 80% coinsurance | 80% coinsurance | |
| If you need immediate medical attention | Emergency room care | 80% coinsurance | 80% coinsurance | $100 penalty for non-emergency services |
| | Emergency medical transportation | 80% coinsurance | 80% coinsurance | None |
| | Urgent care | 80% coinsurance | 80% coinsurance | None |

| 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 have a hospital stay | Facility fee (e.g., hospital room) | 80% coinsurance | 80% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced. |
| | Physician/surgeon fees | 80% coinsurance | 80% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 80% coinsurance | 80% coinsurance | May require preauthorization, |
| | Inpatient services | 80% coinsurance | 80% coinsurance | |
| If you are pregnant | Office visits (pre and postnatal care) | 80% coinsurance | 80% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 80% coinsurance | 80% coinsurance for non-PPO facilities in the Municipality of Anchorage; all others same as network providers | |
| | Childbirth/delivery facility services | 80% coinsurance | 80% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 80% coinsurance | 80% coinsurance | 120 visits/year |
| | Rehabilitation services | 80% coinsurance | 80% coinsurance | No limit for rehabilitation services to restore and improve bodily functions lost due to injury or illness. Limit of 20 visits per year for chiropractic, massage therapy and acupuncture services combined. |
| | Habilitation services | Not covered | Not covered | No coverage for habilitation services except following cochlear implants |
| | Skilled nursing care | 80% coinsurance | 80% coinsurance | Preauthorization is required |
| | Durable medical equipment | 80% coinsurance | 80% coinsurance | None |
| | Hospice services | 80% coinsurance | 80% coinsurance | None |
| If your child needs dental or eye care | Children's eye exam | No charge | No charge up to $150 | Coverage limited to one exam/plan year |
| | Children's glasses | No charge for basic single vision or lined lenses; frames up to $150 | No charge up to $175 for basic single vision lenses; frames up to $150 | Coverage limited to lenses every plan year and frames every other plan year |
| | Children's dental exams | No charge | No charge | $2,000 maximum benefits per plan year |

## 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.)**

- Custodial care
- Cosmetic surgery
- Experimental or investigational services
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine foot care
- Work-related services for treatment for on-the-job injuries

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (adults)
- Hearing Aids
- Non-emergency care when traveling outside the U.S. (must be in an accredited facility)
- Routine eye care (adults)
- Weight Loss Programs (under medical supervision)

**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 1.866.444.3272 or www.dol.gov/ebsa, or the Center for Medicare and Medicaid Services at 1.877.267.2323, x61565 for the Health Insurance Hotline 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 the Health Trust Administrator at 1.866.553.8206.

**Does this plan provide Minimum Essential Coverage?** Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1.866.874.3972, # 781115

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.866.874.3972, # 781115

*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 | $0 |
| Specialist coinsurance | 80% |
| Hospital (facility) coinsurance | 80% |
| Other coinsurance | 80% |

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 | $12,800 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $10,192 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $10,252 |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist coinsurance | 80% |
| Hospital (facility) coinsurance | 80% |
| Other coinsurance | 80% |

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 | $7,400 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $5,920 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Joe would pay is | $5,932 |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist coinsurance | 80% |
| Hospital (facility) coinsurance | 80% |
| Other coinsurance | 80% |

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 | $1,900 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $1,520 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,520 |

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