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, visit www.akufcwtrust.com or call 1-800-478-8329. 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 or call 1-800-478-8329 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 individual / $500 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, Coalition Health Center visits, prescription drugs and preventive dental care are covered when services are provided by a Preferred Provider 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 individual / $50 family for dental services (waived for preventive care). 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: For Preferred Provider $4,500 individual / $9,000 family; for Non-Preferred Provider $12,000 individual / $24,000 family. Prescription Drugs: $3,400 individual / $6,800 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 and charges for services provided at the Coalition Health Center.	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)" for a list of network providers. AK Regional Hospital, Surgery Center of Anchorage and Mat-Su Regional Medical Center are the Preferred Hospitals in Anchorage and the Mat-Su Borough. BridgeHealth surgical program www.bridgehealthmedical.com.	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 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
		Preferred Provider (You will pay the least)	Non-Preferred 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; deductible does not apply	40% coinsurance	Deductible waived and $20 copay/visit for primary care services at the Coalition Health Center (CHC). Copay waived for preventive care. Charges for services provided at the CHC do not apply towards the annual deductible.
	Specialist visit	20% coinsurance	40% coinsurance	24 visit limit/year for Chiropractor. 10 visit limit/lifetime for nutritional counseling.
	Preventive care/screening/ immunization	No charge; deductible does not apply	40% coinsurance	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	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aviapartners.com.	Generic drugs (Tier 1)	retail: the greater of $5 copay or 10% coinsurance/prescription, $30 max. mail order: the greater of $10 copay or 10% coinsurance/prescription, $60 max.	retail: the greater of $5 copay or 10% coinsurance/prescription, $30 max. mail order: the greater of $10 copay or 10% coinsurance/prescription, $60 max.	Covers up to a 34-day supply (retail prescription); 35-90 day supply (mail order prescription). Excluded Pharmacies: benefits will not be provided for, nor will the plan reimburse you for the cost of prescription filled at certain pharmacies, contact Avia Partners. Non-Custom Network Pharmacies: if you fill your prescription at an Avia Partners Pharmacy in Alaska, but outside the Custom Network, you must pay the full cost of prescription and file a claim for reimbursement with Avia Partners. Reimbursement will be based on Avia Partners allowed amount.
	Preferred brand drugs (Tier 2)	retail: the greater of $15 copay or 20% coinsurance/prescription, $75 max. mail order: the greater of $30 copay or 20% coinsurance/prescription, $150 max.	retail: the greater of $15 copay or 20% coinsurance/prescription, $75 max. mail order: the greater of $30 copay or 20% coinsurance/prescription, $150 max.	
	Non-preferred brand drugs (Tier 3)	retail: the greater of $25 copay or 30% coinsurance/prescription. mail order: the greater of $50 copay or 30% coinsurance/prescription.	retail: the greater of $25 copay or 30% coinsurance/prescription. mail order: the greater of $50 copay or 30% coinsurance/prescription.	
	Specialty drugs (Tier 4)	retail: the greater of $15 copay or 20% coinsurance/prescription, $75 max. mail order: the greater of $30 copay or 20% coinsurance/prescription, $150 max.	retail: the greater of $15 copay or 20% coinsurance/prescription, $75 max. mail order: the greater of $30 copay or 20% coinsurance/prescription, $150 max.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Non-emergency orthopedic surgery is not covered if you do not use PPO providers or BridgeHealth.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
	Emergency room care	20% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, no benefits will be paid for hospital charges if it is determined that an inpatient stay was not medically necessary. Non-emergency orthopedic surgery is not covered if you do not use PPO providers or BridgeHealth.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, no benefits will be paid for hospital charges if it is determined that an inpatient stay was not medically necessary.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	No coverage for a dependent child or child of a dependent child. Preauthorization is required for stays in excess of 48 hours for normal delivery or 96 hours cesarean section. Failure to get preauthorization may result in no benefits paid for hospital charges. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	Preauthorization is required. Limited to100 visits/calendar year
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	Covered when rendered due to congenital or developmental conditions to maintain or improve function where significant deterioration in function would result without

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				the therapy. This includes therapy services for Autism Spectrum Disorder.
	Skilled nursing care	No charge	40% coinsurance	Limited to 100 days per disability
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes for prevention purposes, comfort or hygiene, environmental control, exercise, or duplicate.
	Hospice services	20% coinsurance	40% coinsurance	Limited to 30 inpatient days per year
If your child needs dental or eye care	Children's eye exam	$25 copay/exam	Fees in excess of $50	Coverage limited to one exam/year.
	Children's glasses	$35 copay/eyewear	Fees in excess of $50 for single vision lenses and fees in excess of $70 for frames	Coverage limited to one pair of glasses/year.
	Children's dental check-up	20% coinsurance	40% coinsurance	Coverage limited to one exam every 6 months.

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.)

- Cosmetic Surgery (except as necessary for repair of an accidental bodily injury)
- Hearing aids
- Infertility treatment
- Long-term care
- Marital or family counseling
- Massage therapist
- Routine foot care
- Weight loss programs

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

- Acupuncture (if medically necessary and performed by a MD or DO)
- Bariatric surgery (when medically necessary)
- Chiropractic Care (limit 24 visits/year)
- Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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: 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 1-800-478-8329.

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 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 1-800-478-8329.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-478-8329.

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	$250
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$20
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,830

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) 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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$250
Copayments	$400
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,310

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

The plan's overall deductible	$250
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$250
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$650

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