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 1-877-367-0528. 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 or call 1-877-367-0528 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $500 per person / $1,500 per family. | Generally, you must pay all of the costs from provider 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, copays and prescription drugs 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? | Yes, $50 for the Traditional Dental Plan.<br>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: $3,500 per person / $7,000 per family.<br>For Non-Preferred facility and physical therapy providers in the Municipality of Anchorage: $7,000 per person / $14,000 per family. Prescription drugs: $3,000 per person / $6,000 per 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 billed charges, and health care this plan 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 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) network for a list of network providers. Teladoc Teladoc.com 1-800-835-2362. Coalition Health Center www.coalitionhealthcenter.com 907-450-3300. Transcarent (non-emergency surgery outside Alaska) www.transcarent.com 844-249-8108. | 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | Network hospitals, surgical centers and outpatient physical therapy in Anchorage are Alaska Regional Hospital, Surgery Center of Anchorage, New Frontier Anesthesia, Mat-Su Regional Hospital, Alaska Hand Rehabilitation, Ascension Physical Therapy, and Chugach Physical Therapy. | |
| 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 |
|---|---|---|---|---|
| | | 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 visit to treat an injury or illness | $20 copay/visit<br>Deductible does not apply | 20% coinsurance | $30 copay for Wellness and Minor Care Program visits (waived if preventive). Copay waived at the Coalition Health Center. Copay and deductible waived for Teladoc visits. Naturopathic Therapy, Acupuncture and Massage Therapy (Alternative care) limited to 26 combined visits per calendar year. |
| | Specialist visit | $20 copay/visit<br>Deductible does not apply | 20% coinsurance | |
| | Preventive care/screening/ immunization | No charge | No charge | 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. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work)<br>Imaging (CT/PET scans, MRIs) | No charge for preventive.<br>20% coinsurance for diagnostic. | No charge for preventive.<br>20% coinsurance for diagnostic / 40% coinsurance for non-PPO facility in 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. |
| If you need drugs to | Generic drugs | 20% coinsurance | 20% coinsurance | Covers up to a 34-day supply (retail) up to a |

* For more information about limitations and exceptions, see the plan or policy document at www.cementmasonstrust.com.

| 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) | |
| treat your illness or condition<br>More information about prescription drug coverage is available at 1-877-367-0528 and www.savrx.com. | | (retail & mail order) | | 90 day supply (mail order). $50 penalty applies when generic is available and brand is purchased, does not apply to out-of-pocket limit. |
| | Preferred brand drugs | 30% coinsurance (retail & mail order) | 30% coinsurance | |
| | Non-preferred brand drugs | 50% coinsurance (retail & mail order) | 50% coinsurance | |
| | Specialty drugs | 30% coinsurance preferred<br>50% coinsurance non-preferred<br>(retail & mail order) | 30% coinsurance preferred<br>50% coinsurance non-preferred | Prior authorization and step therapy is required. Covers up to 30-day supply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance for non-PPO facility in Anchorage.<br>20% coinsurance 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 | 20% coinsurance | 20% coinsurance | |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | $400 penalty for non-emergency services received in an ER, does not apply to the out-of-pocket limit. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | $20 copay/visit<br>Deductible does not apply | 20% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance for non-PPO facility in Anchorage.<br>20% coinsurance 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. Prior authorization required 50% reduction in benefits for non-compliance. |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $20 copay office visit<br>Deductible does not apply.<br>20% coinsurance all other services | 40% coinsurance for non-PPO facility in Anchorage.<br>20% coinsurance 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 | 20% coinsurance | 40% coinsurance for non-PPO facility in Anchorage. | Prior authorization required. $250 penalty applies to non-PPO facilities. Allowable |

| 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) | |
| | | | 20% coinsurance outside Anchorage. | 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 | $20 copay/visit<br>Deductible does not apply | 20% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service, coinsurance may apply. |
| | Childbirth/delivery professional services | 20% coinsurance | 20% coinsurance | $250 penalty applies to non-PPO facilities. Pregnancy charges for a dependent child are not covered except for certain preventive services. Allowable charges for services at a non-PPO facility in Anchorage will be the rate of the Preferred Provider Hospital. |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance for non-PPO facility in Anchorage. 20% coinsurance outside Anchorage. | |
| If you need help recovering or have other special health needs | Home health care | No charge<br>deductible does not apply | No charge<br>deductible does not apply. | Limited to 130 visits per year. Patient must be home bound. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance for non-PPO provider in Anchorage. 20% coinsurance outside Anchorage. | $250 penalty applies to non-PPO facility for inpatient services. Allowable charges for services at a non-PPO facility or physical therapy provider in Anchorage will be the rate of the Preferred Provider Hospital or Chugach Physical Therapy, or 50% of the billed charge if no rate is established. Outpatient visits limited to 40 per year unless treatment of a mental disorder. |
| | Habilitation services | 20% coinsurance | 40% coinsurance for non-PPO provider in Anchorage. 20% coinsurance outside Anchorage. | |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | 120 day maximum limit |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Requires physician's prescription |
| | Hospice services | 20% coinsurance | 20% coinsurance | None |
| If your child needs dental or eye care | Children's eye exam | $10 copay/exam | $10 copay/exam plus | Limited to one exam every 12 months from the last date of service. |

* For more information about limitations and exceptions, see the plan or policy document at www.cementmasonstrust.com.

| 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) | |
| | | | charges in excess of $45 | |
| | Children's glasses | $25 copay plus charges in excess of $120 for frames | $25 copay plus charges in excess of $45 for single vision lenses and charges in excess of $47 for frames | Lenses limited to one pair every 12 months from the date of last services. Frames limited to one pair every 24 months from date of last service. |
| | Children's dental check-up | Diagnostic/preventive 0% to 30% depending on nature of services | Diagnostic/preventive 0% to 30% depending on nature of services | Dental check-ups limited to one exam in any period of 6 consecutive months. Annual maximum of $2,500. |

## 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.) | | |
|---|---|---|
| • Bariatric surgery<br>• Cosmetic surgery (unless performed for correction of functional disorders or as a result of an accidental injury)<br>• Diabetic education | • Infertility treatment<br>• Long-term care<br>• Pregnancy charges for a dependent child<br>• Routine foot care | • Sex transformation<br>• Marital, sex, or family counseling<br>• Weight loss programs<br>• Work related injuries or illness |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture, naturopathic and massage therapy (Alternative care is limited to 26 combined visits per calendar year)<br>• Chiropractic care | • Dental care (Adult)<br>• Hearing Aids<br>• Gene and cellular therapy<br>• Telemedicine | • Non-emergency care when traveling outside the U.S.<br>• Private duty nursing<br>• Routine eye care (Adult) See www.vsp.com |

**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 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 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. You may also contact the Trust Administration Office at 1-877-367-0528.

**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 1-877-367-0528.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-367-0528.

*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 | $500 |
| Specialist copay | $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 | $12,700 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $0 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $2,960 |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copay | $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 | $5,600 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $200 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| The total Joe would pay is | $1,820 |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist copay | $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 | $2,800 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $60 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $960 |

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