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?	**$2,000** per person / **$4,000** 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, home health care 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?	No.	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. 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 www.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. Network hospitals, surgical centers and outpatient physical therapy in Anchorage are Alaska Regional	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:
	Hospital, Surgery Center of Anchorage, New Frontier Anesthesia, and Mat-Su Regional Hospital.	
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 Deductible does not apply	30% coinsurance	$30 copay for Wellness and Minor Care Program visits (waived if preventive). Copay waived at the Coalition Health Center. Naturopathic Therapy, Acupuncture and Massage Therapy (Alternative care) limited to 26 combined visits per calendar year. Non-surgical spinal treatment limited to 25 visits per calendar year.
	Specialist visit	$20 copay/visit Deductible does not apply	30% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	Allowable charges for services at a non-PPO facility in the Municipality of 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) Imaging (CT/PET scans, MRIs)	No charge for preventive. 30% coinsurance for diagnostic	No charge for preventive. 30% coinsurance for diagnostic	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 treat your illness or condition More information about **prescription drug**	Generic drugs	20% coinsurance (retail & mail order)	20% coinsurance	Covers up to a 30-day supply (retail) 31 – 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	50% coinsurance	

* 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)	
coverage is available at www.savrx.com		(retail & mail order)		
	Specialty drugs	30% coinsurance preferred /50% coinsurance non-preferred (retail & mail order)	30% coinsurance preferred /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)	30% coinsurance	30% coinsurance	Allowable charges for facility services at a non-PPO facility in the Municipality of 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% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	$400 penalty for non-emergency services received in an ER, does not apply to the out-of-pocket limit.
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	$20 copay/visit Deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	30% coinsurance	$250 penalty applies to non-PPO facilities. Allowable charges for services at a non-PPO facility in the Municipality of 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% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay office visit Deductible does not apply. 30% coinsurance all other services	30% coinsurance	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% coinsurance	30% coinsurance	Prior authorization required, 50% reduction in benefits for non-compliance. $250 penalty applies to non-PPO facilities. Allowable charges for services at a non-PPO facility in the Municipality of

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)	
				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 Deductible does not apply	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, coinsurance may apply.
	Childbirth/delivery professional services	30% coinsurance	30% 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 the Municipality of Anchorage will be the rate of the Preferred Provider Hospital or 50% of the billed charge if no rate is established.
	Childbirth/delivery facility services	30% coinsurance	30% coinsurance	
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 130 visits per year. Patient must be home bound.
	Rehabilitation services	30% coinsurance	30% coinsurance.	$250 penalty applies to non-PPO facility for inpatient services and Prior authorization required, 50% reduction in benefits for non-compliance when inpatient. Allowable charges for services at a non-PPO facility or physical therapy provider in the Municipality of Anchorage will be the rate of the Preferred Provider Hospital or PPO Physical Therapy provider, 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	30% coinsurance	30% coinsurance	
	Skilled nursing care	30% coinsurance	30% coinsurance	120 day maximum limit
	Durable medical equipment	30% coinsurance	30% coinsurance	Requires physician's prescription
	Hospice services	30% coinsurance	30% 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 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.)

- Bariatric surgery
- Cosmetic surgery (unless performed for correction of functional disorders or as a result of an accidental injury)
- Diabetic education
- Dental Care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Pregnancy charges for a dependent child
- Routine eye care (Adult)
- Routine foot care
- Marital, sex, or family counseling
- Weight loss programs
- 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)
- Chiropractic care
- Gene and cellular therapy
- Telemedicine
- Non-emergency care when traveling outside the U.S.
- Private duty nursing

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	$2,000
Specialist copay	$20
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

The plan's overall deductible	$2,000
Specialist copay	$20
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$200
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$2,000
Specialist copay	$20
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$60
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,160**

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