



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](http://www.dol.gov/ebsa/healthreform) or call 1-877-367-0528 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$2,000 per person / \$4,000 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 plan 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="#">Preventive care</a> , copays, home health care and <a href="#">prescription drugs</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 plan covers certain <a href="#">preventive services</a> 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 must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these 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. <a href="#">Prescription drugs</a> : \$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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	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 <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 <a href="http://www.teladoc.com">www.teladoc.com</a> 1-800-835-2362, 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. <a href="#">Network hospitals</a> , surgical centers and outpatient physical therapy in Anchorage are Alaska Regional	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 plan's <a href="#">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 <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.

Important Questions	Answers	Why This Matters:
	Hospital, Surgery Center of Anchorage, New Frontier Anesthesia, and Mat-Su Regional Hospital.	
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 office</a> or <a href="#">clinic</a>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	\$30 <a href="#">copay</a> for Wellness and Minor Care Program visits (waived if preventive). <a href="#">Copay</a> 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.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work) Imaging (CT/PET scans, MRIs)	No charge for preventive. 30% <a href="#">coinsurance</a> for diagnostic	No charge for preventive. 30% <a href="#">coinsurance</a> 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 <a href="#">prescription drug</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 <a href="#">out-of-pocket limit</a> .
	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>	50% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.cementmasonstrust.com](http://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)	
<a href="http://www.savrx.com">coverage</a> is available at <a href="http://www.savrx.com">www.savrx.com</a>		(retail & mail order)		
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a> preferred /50% <a href="#">coinsurance</a> non-preferred (retail & mail order)	30% <a href="#">coinsurance</a> preferred /50% <a href="#">coinsurance</a> non-preferred	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>	30% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</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 <a href="#">out-of-pocket limit</a> .
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">copay</a> office visit <a href="#">Deductible</a> does not apply. 30% coinsurance all other services	30% <a href="#">coinsurance</a>	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>	30% <a href="#">coinsurance</a>	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

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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 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	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.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	\$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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
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>	30% <a href="#">coinsurance</a> .	\$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.
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<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

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.cementmasonstrust.com](http://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)	
<b>If your child needs dental or eye care</b>	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

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

**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 1-877-367-0528.

### 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,500
<i>What isn't covered</i>	
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 [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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,120</b>

### 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,160</b>

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