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.apea-afttrust.com call 1-800-331-6158. 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 1-800-331-6158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600** per person / **$1,800** per 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 services 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.
Are there other deductibles for specific services?	Yes. $500 per person for prescription drug coverage. $50.00 emergency room deductible. 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?	**$1,250** per person / **$3,750** 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, deductibles, copayments, balance billed charges, and health care this plan does not cover.	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. In Anchorage/Mat-Su, the preferred provider facilities are Providence Medical Center and Mat-Su Regional Hospital. BridgeHealth-non-emergency surgery outside Alaska www.bridgehealth.com or 844-249-8108. For Teladoc see www.Teladoc.com or call 800-835-2362.	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	20% coinsurance	Teladoc consultations are covered at 100%. Acupuncture services limited to 12 visits/calendar year. Rehabilitation therapy (massage, physical and occupational) limited to 45 visits/calendar year combined.
	Specialist visit	20% coinsurance	20% coinsurance	
	Preventive care/screening/ immunization	No charge Deductible does not apply	No charge Deductible does not apply	Routine physicals limited to one per year age 2 and older. Birth to 1st birthday 6 exams, 1st to 2nd birthday 2 exams. Routine labs, x-rays and screenings as recommended by the American Cancer Society. 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)	20% coinsurance	20% coinsurance	None. You will pay 40% for use of a non-PPO Facility.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	Preauthorization is required. Refer to Medical Rehab Consultants at 1-800-827-5058. You will pay 40% for use of a non-PPO facility. There is no coverage for services that are not preauthorized and are found to be not Medically Necessary.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$10 copay/prescription retail $20 copay/prescription mail order	$10 copay/prescription retail $20 copay/prescription mail order	The prescription drug deductible does not apply to generic drugs. Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). You must pay in full for prescriptions purchased at a non-PPO pharmacy and then file a claim with Caremark for reimbursement.
	Preferred brand drugs	$25 copay/prescription retail $50 copay/prescription mail order	$25 copay/prescription retail $50 copay/prescription mail order	
	Non-preferred brand drugs	$45 copay/prescription retail	$45 copay/prescription retail	

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)	
		$90 copay/prescription mail order	$90 copay/prescription mail order	
	Specialty drugs	$25 copay/prescription preferred; $45 copay/prescription non-preferred	$25 copay/prescription preferred; $45 copay/prescription non-preferred	Specialty medications limited to a 30-day supply; preauthorization is required. Step Therapy is required. Visit www.CVSCaremarkSpecialtyRx.com or call 1-866-814-5506 for more information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required for all inpatient and outpatient surgeries (except those done in a doctor's office). Refer to Medical Rehab Consultants at 1-800-827-5058. There is no coverage for services that are not preauthorized and are found to be not Medically Necessary.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	$50 deductible/visit plus 20% coinsurance	$50 deductible/visit plus 40% coinsurance	$50 deductible waived if admitted to hospital. Non-PPO applies to hospitals in Anchorage and lower 48 only.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required; refer to Medical Rehab Consultants at 1-800-827-5058. There is no coverage for services that are not preauthorized and are found to be not Medically Necessary. Non-PPO applies to hospitals in Anchorage and lower 48 states only.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	None
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services,

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)	
				a coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	No coverage for child of a dependent child
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization is required; refer to Medical Rehab Consultants at 1-800-827-5058. Limited to 130 visits per calendar year. There is no coverage for services that are not preauthorized and are found to be not Medically Necessary.
	Rehabilitation services	20% coinsurance	20% coinsurance	Rehabilitation services limited to 45 (combined)visits for occupational, massage and physical therapy.
	Habilitation services	20% coinsurance	20% coinsurance	Must be Medically Necessary, prescription and treatment plan required.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required; refer to Medical Rehab Consultants at 1-800-827-5058. Limited to 120 days per calendar year. There is no coverage for services that are not preauthorized and are found to be not Medically Necessary.
	Durable medical equipment	20% coinsurance	20% coinsurance	Limited to $5,000 per calendar year. Rental to purchase; prescription required.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required; refer to Medical Rehab Consultants at 1-800-827-5058. Limited to 10 days (inpatient) or six months (outpatient) per calendar year. There is no coverage for services that are not preauthorized and are found to be not Medically Necessary.
If your child needs dental or eye care	Children's eye exam	$25 copay/exam plus costs above the VSP schedule	$25 copay/exam plus costs above the VSP schedule	Vision benefits provided through Vision Service Plan. Contact www.vsp.com or 1-800-877-7195. Eye exam limited to one every
	Children's glasses	Costs above the VSP	Costs above the VSP	

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)	
		schedule	schedule	12 months. Glasses limited to 1 set of lenses every 12 months and frames are limited to 1 every 24 months.
	Children's dental check-up	No cost for preventive services	No cost for preventive services	Limited to two examinations in a 12-month period.

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
- Infertility treatment
- Long-term care
- Mental/Behavioral treatments
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Substance abuse treatment
- Weight loss programs

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

- Acupuncture (limited to 12 visits per calendar year)
- Chiropractic care
- Dental care (Adult)
- Hearing Aids (limited to $800)
- Private-duty nursing (limited to 70 visits per calendar year
- 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 1-866-444-3272 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 x 61565 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-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact the Administration Office at 1-800-331-6158.

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 1-800-331-6158.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-331-6158.

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	$600
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	$600
Copayments	$40
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,000**

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

The plan's overall deductible	$600
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	$1,100
Copayments	$600
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

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

The plan's overall deductible	$600
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	$600
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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