



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 1-800-331-6158. 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.dol.gov/ebsa/healthreform or call 1-800-331-6158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$900 per person / \$2,700 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 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. \$50 for Emergency room. \$50 per person/ \$150 per family for dental expenses. 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: \$2,500 per person / \$7,500 per family. Prescriptions: \$2,000 per person / \$6,000 per family	The out-of-pocket limit is the most you could pay in a year for covered services, this includes your deductible, copays, and coinsurance . 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.	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. Transcarent-non-emergency surgery outside Alaska www.transcarent.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
		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% coinsurance	20% coinsurance	Teladoc consultations are covered as regular office visits. Acupuncture services limited to 12 visits/calendar year. Rehabilitation therapy (massage, physical and occupational) limited to 45 visits/calendar year combined.
	Specialist visit			
	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 1 st birthday 6 exams, 1 st to 2 nd 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	You will pay 50% for use of a non-PPO facility.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	Preauthorization is required. Refer to Personify at 1-800-827-5058. You will pay 50% 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	Effective 10/1/2026** \$20 copay /prescription retail \$40 copay /prescription mail order	Effective 10/1/2026** \$20 copay /prescription retail \$40 copay /prescription mail order	Non-formulary drugs may not be covered without approval through the prior-authorization process. To review preferred prescription drugs , see the formulary at www.caremark.com . 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	Effective 10/1/2026** \$50 copay /prescription retail \$100 copay /prescription mail order	Effective 10/1/2026** \$50 copay /prescription retail \$100 copay /prescription mail	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.apea-afttrust.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)	
			order	
	Non-preferred brand drugs	Effective 10/1/2026** \$90 copay /prescription retail \$180 copay /prescription mail order	Effective 10/1/2026**	
	Specialty drugs	Effective 10/1/2026** 30% coinsurance	Effective 10/1/2026** Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Covers up to 30-day supply. Only covered at CVS Caremark specialty pharmacy. Prior authorization required for some drugs. PrudentRx affects your coinsurance for certain drugs. See https://www.prudentrx.com/prudentrxs/ for more information.
	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 50% 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	50% coinsurance	Preauthorization is required; refer to Personify 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

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.apea-afttrust.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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	You will pay 50% for use of a non-PPO facility.
	Inpatient services	20% coinsurance	50% coinsurance	<u>Preauthorization</u> is required; refer to Personify at 1-800-827-5058.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, 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	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	<u>Preauthorization</u> is required; refer to Personify 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 <u>Medically Necessary</u> .
	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 <u>Medically Necessary</u> , prescription and treatment plan required.
	Skilled nursing care	20% coinsurance	50% coinsurance	<u>Preauthorization</u> is required; refer to Personify 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 <u>Medically Necessary</u> .
	Durable medical equipment	20% coinsurance	20% coinsurance	Rental to purchase; prescription required.
	Hospice services	20% coinsurance	50% coinsurance	<u>Preauthorization</u> is required; refer to Personify at 1-800-827-5058. Limited to 10 days (inpatient) or six months (outpatient) per calendar year. There is no

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 for services that are not preauthorized and are found to be not <u>Medically Necessary</u> .
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> /exam plus costs above the VSP schedule	\$25 <u>copay</u> /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 12 months. Glasses limited to 1 set of lenses every 24 months and frames are limited to 1 every 24 months.
	Children's glasses	Costs above the VSP schedule	Costs above the VSP schedule	
	Children's dental check-up	No cost for preventive services	No cost for preventive services	Limited to two examinations in a 12-month period.

****9/1/2026 – 9/30/2026: Prescription drug copays are as follows (retail / mail order): Generic: \$10 copay / \$20 copay, Brand Formulary: \$25 copay / \$50 copay, Brand-Non-Formulary: \$45 copay / \$90 copay, Specialty: \$25 copay / \$45 copay.**

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Cosmetic surgery • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S.	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Acupuncture (limited to 12 visits per calendar year) • Chiropractic care	• Dental care (Adult) • Hearing Aids (limited to \$800) • Obesity treatment	• 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: 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 1-800-331-6158.

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 1-800-331-6158.

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

About these Coverage Examples:

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.



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	\$800
■ 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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$10
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,360

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$800
■ 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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$500
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$800
■ 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$10
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,210

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