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.aetf.com or call (907) 276-1246. 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 https://www.healthcare.gov/sbc-glossary/ or call (907) 276-1246 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/individual or $1,500/family.	Generally, you must pay all 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 is 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. $300 / confinement in in-network provider hospitals and $600 / confinement in out-of-network provider hospitals. 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 charges up to the allowed amount are paid at 80% up to $2,500/ individual, $5,000/family, then 90% up to $5,000/person, $10,000/ family; then at 100% thereafter. For prescription drugs, $750/person and $1,500/family per calendar year	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. 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?	Coinsurance for certain services, premiums, balance billing charges, out-of-network coinsurance, copayments and penalties, penalties for failure to obtain preauthorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count towards the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See aetf.com or call (800) 478-1246 for a list of in-network providers	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
		In-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 of the allowed amount		Chiropractic – maximum of 24 visits/calendar year. Mechanized spinal distraction therapy – lifetime maximum of 20 visits, $175/ session. Infertility treatments – lifetime maximum $12,000.
	Specialist visit	20% coinsurance of the allowed amount		
	Preventive care/screening/ immunization	No charge		Routine physical exams - once every 5 years up to age 40. Once every 2 years from 40-49. Once a year age 50 and over.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 20% of the allowed amount	For out-of-network provider services not performed in a physician's office, the 20% reduction in reimbursement rates is applied to the first $50,000 in covered charges. Maximum X-ray exam in connection with spinal therapy, $100/individual.
	Imaging (CT/PET scans, MRIs)	20%coinsurance	40% coinsurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 20% of the allowed amount	For out-of-network provider services not performed in a physician's office, the 20% reduction in reimbursement rates in Anchorage area or outside Alaska is applied to the first $50,000 in allowed amount.

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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail: $15 copayment Mail Order: $30 copayment	Same copayment as network provider, plus any amount in excess of the network provider price	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).
	Brand-name drugs	If generic is not available: Retail: $35 copayment Mail order: $70 copayment Not covered if generic is available	Same copayment as network provider, plus amount in excess of network provider price	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 20% of the allowed amount	For out-of-network provider, 20% reduction in reimbursement rates in Anchorage area or outside Alaska is applied to the first $50,000 in allowed amount. Preauthorization required for some procedures.
	Physician/surgeon fees	20% coinsurance of the allowed amount		None.
If you need immediate medical attention	Emergency room care	$100 copayment.	$100 copayment	Copayment is waived if directly admitted to hospital from ER
	Emergency medical transportation	20% coinsurance	20% coinsurance of the allowed amount	None
	Urgent care	20% coinsurance	20% coinsurance of the allowed amount	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance of the allowed amount if in the Anchorage area or outside Alaska, otherwise 20% of the allowed amount plus a $1,000 penalty.	For out-of-network provider, the 20% reduction in reimbursement rates in the Anchorage area or outside Alaska is applied to the first $50,000 in allowed amount. Preauthorization required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance of the allowed amount	None

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
		In-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 of the allowed amount		None
	Inpatient services	20% coinsurance	40% coinsurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 20% of the allowed amount plus a $1,000 penalty.	For out-of-network provider, the 20% reduction in reimbursement rates is applied to the first $50,000 in allowed amount. Preauthorization required
	Substance use disorder outpatient services	20% coinsurance of the allowed amount		None
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 20% of the allowed amount.	For out-of-network provider, the 20% reduction in reimbursement rates if in Anchorage area or outside Alaska is applied to the first $50,000 in allowed amount. Preauthorization required
If you are pregnant	Office visits	20% coinsurance of the allowed amount.		Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery and all inpatient services	20% coinsurance	40% coinsurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 20% of the allowed amount plus a $1,000 penalty.	For out-of-network provider, the 20% reduction in reimbursement rates if in Anchorage area or outside Alaska is applied to the first $50,000 in allowed amount. Preauthorization required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance of the allowed amount	130 visits/calendar year. Preauthorization required.
	Rehabilitation services	20% coinsurance	For physical and occupational therapy, 40% coinsurance of the allowed amount if in Anchorage area. Otherwise 20% of the allowed amount	Limited to services necessary to improve function or to maintain function where significant deterioration in function would result without the therapy.
	Habilitation services			

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
		In-Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Skilled nursing care	20% coinsurance	40% coinsurance of the allowed amount if outside Alaska, otherwise 20% of the allowed amount	For out-of-network provider, the 20% reduction in reimbursement rates is applied to the first $50,000 in allowed amount. Preauthorization. Maximum 120 days/year for same or related illness or injury. Preauthorization required.
	Durable medical equipment	20% coinsurance.		None.
	Hospice services	20% coinsurance.		Up to maximums of $150/day, $10,000/lifetime.
If your child needs dental or eye care	Children's eye exam	$20 copayment.	Charges over $45.	No more than once annually.
	Children's glasses	$30 copayment.	Charges over $45 – single. Charges over $65 – lined bifocal. Charges over $85 – lined trifocal. Charges over $125 – lenticular.	Frames every 24 months. Lenses and contacts every 12 months.
	Children's dental check-up	No charge.	No charge.	No more than twice in any calendar year. $2,000 maximum/year does not apply to children under age 19.

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.)

- Cosmetic surgery
- Long-term care
- Routine foot care
- Weight loss programs

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

- Acupuncture.
- Bariatric surgery with preauthorization. Lifetime maximum of $50,000
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment (Up to a lifetime maximum of $12,000)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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 (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 (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: Alaska Electrical Health & Welfare Fund, 701 E Tudor, Suite 200, Anchorage, AK 99503, (907) 276-1246.

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:
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 478-1246.
Spanish (Español): Para obtener asistencia en Español, llame al (800) 478-1246.

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 *coinsurance*	20%
Hospital (facility)	$300 + 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	**$12,755**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500*
Copayments	$60
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,100**

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 *coinsurance*	20%
Hospital (facility)	$300 + 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	**$7,465**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$920
Coinsurance	$430
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$1,900**

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

The plan's overall deductible	$500
Specialist *coinsurance*	20%
Hospital (facility)	$300 + 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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500*
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

*This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"
Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Administrative Office at (907) 276-1246.
The plan would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM – Notice of Nondiscrimination

The Alaska Electrical Health & Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Alaska Electrical Health & Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Alaska Electrical Health & Welfare Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Patti Janusiewicz.

If you believe that the Alaska Electrical Health & Welfare Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Patti Janusiewicz, Health & Welfare Supervisor, 701 E. Tudor, Suite 200, Anchorage, AK 99503 (907) 276-1246, Fax: (907) 278-7576. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Patti Janusiewicz is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 478-1246.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 478-1246.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 478-1246. 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 478-1246.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 478-1246.

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: (800) 478-1246.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 478-1246.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 478-1246.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 478-1246.

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti (800) 478-1246.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 478-1246.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (800) 478-1246.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 478-1246.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 478-1246.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 478-1246.