This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.aetf.com or by calling (907) 276-1246.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$600/person $1,200/family Does not apply to routine preventive care or prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. $300/confinement in In-Network hospital and $600/confinement in Out-of-Network hospital.	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.
Is there an out–of–pocket limit on my expenses?	Yes. Medical Covered Charges paid at 85% - up to $2,700/family and paid at 90% up to $5,400/family, then 100% thereafter. Prescription drugs, $750/individual and $1,500/family.	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.
What is not included in the out–of–pocket limit?	Premiums, certain out-of-network co-insurance, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see **www.aetna.com/docfind** or call 1-800-478-1246. In Anchorage area, Alaska Regional and MatSu Valley are network Hospitals.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% co-insurance of the allowed amount		Chiropractic – maximum of 24 visits per year. Mechanized spinal distraction therapy – lifetime maximum of 20 visits at $175/session. Infertility treatments - lifetime maximum $12,000.
	Specialist visit	15% co-insurance of the allowed amount		
	Other practitioner office visit	15% co-insurance of the allowed amount		
	Preventive care/ screening/immunization	No charge		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)	15% co-insurance	35% co-insurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 15% of the allowed amount	For Out-of-Network 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)	15% co-insurance	35% co-insurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 15% of the allowed amount	For Out-of-Network services not performed in a physician's office, the 20% reduction in reimbursement rates is applied to the first $50,000 in covered charges.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
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 co-payment Mail Order: $30 co-payment	Same co-payment as in network, plus amount in excess of In-network pharmacy price.	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Brand drugs	If generic is not available: Retail: $35 co-payment Mail order: $70 co-payment Not covered if generic is available	Same co-payment as in network, plus amount in excess of In-network pharmacy 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)	15% co-insurance	35% co-insurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 15% of the allowed amount	For Out-of-Network services, the 20% reduction in reimbursement rates is applied to the first $50,000 in covered charges.
	Physician/surgeon fees	15% co-insurance of the allowed amount		---none---
If you need immediate medical attention	Emergency room services	$100 **co-payment**	$100 **co-payment**	**Co-payment** is waived if directly admitted to hospital from ER.
	Emergency medical transportation	15% co-insurance	15% co-insurance of the allowed amount	---none---
	Urgent care	15% co-insurance	15% co-insurance of the allowed amount	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	15% co-insurance	35% co-insurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 15% of the allowed amount	For Out-of-Network services, the 20% reduction in reimbursement rates is applied to the first $50,000 in covered charges. Preauthorization required.
	Physician/surgeon fee	15% co-insurance	15% co-insurance of the allowed amount	---none---

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% co-insurance of the allowed amount		---none---
	Mental/Behavioral health inpatient services	15% co-insurance	35% co-insurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 15% of the allowed amount	For Out-of-Network services, the 20% reduction in reimbursement rates is applied to the first $50,000 in covered charges. Preauthorization required.
	Substance use disorder outpatient services	15% co-insurance of the allowed amount		---none---
	Substance use disorder inpatient services	15% co-insurance	35% co-insurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 15% of the allowed amount	For Out-of-Network services, the 20% reduction in reimbursement rates is applied to the first $50,000 in covered charges. Preauthorization required
If you are pregnant	Prenatal and postnatal care	15% co-insurance of the allowed amount		---none---
	Delivery and all inpatient services	15% co-insurance	35% co-insurance of the allowed amount if in Anchorage area or outside Alaska, otherwise 15% of the allowed amount	For Out-of-Network services, the 20% reduction in reimbursement rates is applied to the first $50,000 in covered charges. Automatically covers stay up to 48 hours, or if C-section, stay up to 96 hours.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	15% co-insurance	15% co-insurance of the allowed amount	Up to 130 visits per calendar year. Preauthorization required.
	Rehabilitation services	15% co-insurance	For physical and occupational therapy 35% co-insurance of the allowed amount if in Anchorage area. Otherwise 15% of the allowed amount.	Services necessary to improve function or to maintain function where significant deterioration in function would result without the therapy.
	Habilitation services			
	Skilled nursing care	15% co-insurance	35% co-insurance of the allowed amount if outside Alaska, otherwise 15% of the allowed amount	For Out-of-Network services, the 20% reduction in reimbursement rates is applied to the first $50,000 in covered charges. Maximum of 120 days per calendar year/same or related illness or injury. Preauthorization required.
	Durable medical equipment	15% co-insurance	15% co-insurance	---none---
	Hospice service	15% co-insurance	15% co-insurance	Maximum allowed amount of $150/day. Lifetime maximum of $10,000
If your child needs dental or eye care	Eye exam	Not covered	Not covered	See SBC for vision plans.
	Glasses	Not covered	Not covered	See SBC for vision plans.
	Dental check-up	Not covered	Not covered	See SBC for dental plans.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (if medically necessary)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (907) 276-1246. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/health reform.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Alaska Electrical Health & Welfare Fund, 701 E Tudor, Suite 200, Anchorage, AK 99503, (907) 276-1246. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/health reform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. This minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 331-6158.

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

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,030
- **Patient pays** $2,510

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Co-pays	$20
Co-insurance	$840
Limits or exclusions	$150
Total	**$2,510**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,010
- **Patient pays** $1,390

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$600
Co-pays	$540
Co-insurance	$170
Limits or exclusions	$80
Total	**$1,390**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan at *www.aetf.com* or by calling **(907) 276-1246**. This is Appendix A to your Medical Plan SBC.

Important Questions	Answers						Why this Matters:
Plan Name	601	602	603	604	605	606	
What is the overall deductible?	$0	$0	$25/ person & $75/ family	$0	$50/ person & $150/ family	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	$25/ person & $75/ family	No.	$25/ person & $75/ family	No.	No	For Plans 602 and 604, you must pay all of the costs for restorative and major dental services up to the specific **deductible** amount before the plan begins to pay for these services. You don't have to meet **deductibles** for these dental services for Plans 601, 603, 605 and 606.
Is there an out–of–pocket limit on my expenses?	No.						There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	The plans have no **out-of-pocket limit**.						Not applicable because there is no **out-of-pocket** limit on your expenses.
Is there an overall annual limit on what the plan pays?	$2,000		$1,500		$1,000	$1,500	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit.
	Limits do not apply to dependent children under age 19.						
Does this plan use a network of providers?	No.						This plan treats **providers** the same in determining payment for the same services.
Do I need a referral to see a specialist?	No.						You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.						Some of the services this plan doesn't cover are listed on page 2. See your plan document for additional information about **excluded services**.

Common Medical Event	Services You May Need	Your Cost (Co-Insurance)						Limitations & Exceptions
		601	602	603	604	605	606	
If your child needs dental	Dental check-up	10%	None	30%	30%	40%	60%	Annual maximums apply *only* for dependents age 19 and older as follows: Plans 601, 602 – $2,000 Plans 603, 604 and 606 – $1,500 Plan 605 – $1,000

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Orthodontia (Plans 602, 604 and 605)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Orthodontia (children only – Plans 601, 603 and 606)
- Dental Care (Adult)

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan at *www.aetf.com* or by calling **(907) 276-1246**. This is Appendix B to the Medical Plan SBC.

Important Questions	Answers				Why this Matters:
Plan Name	701	702	703	704	
What is the overall deductible?	$0				See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.				You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.				There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	The plans have no **out-of-pocket limits**.				Not applicable because there is no **out-of-pocket** limit on your expenses.
Is there an overall annual limit on what the plan pays?	No.				The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Visit www.vsp.com or call VSP at (877) 478-1246.				If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.				You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.				Some of the services this plan doesn't cover are listed on page 2. See your plan document for additional information about **excluded services**.

Common Medical Event	Services You May Need		Your Cost (Co-Payment)					Limitations & Exceptions
			701 (VSP)	702 (VSP)	703 (VSP)	704 (VSP)	Non-VSP	
If your child needs eye care	Eye exam		$10/person – co-payment	$20/person - co-payment			Charges over $45/person	Benefits for Plans 701, 702 and 703 are per each 12-month period. Plan 704 is per each 24-month period.
	Glasses	Co-payment	$20	$30	$40	$40	All co-payments outlined apply to VSP and Non-VSP provider claims.	
		Lenses	$0				Single -- Charges over $45 Lined bifocal --Charges over $65 Lined trifocal-- Charges over $85 Lenticular --Charges over $125	
		Frames	80% of charges over $120				Charges over $47	

Other Covered Services:

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Contact lenses
- Routine eye care (Adult)