This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan's summary plan description at **www.akufcwtrust.com** or by calling **1-800-478-8329.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person / **$500** family Doesn't apply to routine physical exams, preventive care, prescription drugs, and well child care.	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?	**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?	Yes. Medical: **$4,500** per person / **$9,000** per family for PPO providers; **$6,000** per person / **$12,000** per family for non-PPO providers. Prescription: **$2,650** per person / **$5,300** per 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, 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. Alaska Regional Medical Center in Anchorage and Mat-Su Regional Medical Center. For a list of preferred providers nationwide, see www.aetna.com/docfind and select Aetna Choice® POS II (open access) network. To locate a pharmacy **www.aviapartners.com** or call **(800) 273-9166.**	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 don't need a referral to see a specialist.	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**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 preferred (PPO) **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	————————none————————
	Specialist visit	20% coinsurance	20% coinsurance	————————none————————
	Other practitioner office visit	20% coinsurance	20% coinsurance	Chiropractor visits limited to 24 per year. Massage therapist visits are not covered. Nutritional counseling visits limited to 10 per lifetime.
	Preventive care/ screening/immunization	No charge	20% coinsurance	30% coinsurance applies if care is obtained at a non-PPO hospital in Anchorage.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	30% coinsurance applies if care is obtained at a non-PPO hospital in Anchorage.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.aviapartners.com**	Generic drugs	Retail: the greater of $5 or 10%, $30 max. Mail: the greater of $10 or 10%, $60 max.	Retail: the greater of $5 or 10%, $30 max. Mail: the greater of $10 or 10%, $60 max.	Covers up to a 34-day supply (retail prescription); 35-90 day supply (mail order prescription). **Excluded Pharmacies**: Benefits will not be provided for nor will the plan reimburse you for the cost of prescriptions filled at certain pharmacies, contact Avia Partners. **Non-Custom Network pharmacies**: If you fill your prescription at an Avia Partners Pharmacy in Alaska, but outside the Custom Network you must pay full cost of prescription and file a claim for reimbursement with Avia Partners. Reimbursement will be based on Avia Partners allowed amount.
	Brand drugs no generic available	Retail: the greater of $15 or 20%, $75 max. Mail: the greater of $30 or 20%, $150 maximum	Retail: the greater of $15 or 20%, $75 max. Mail: the greater of $30 or 20%, $150 maximum	
	Brand drugs if generic available	Retail: the greater of $25 or 30% Mail: the greater of $50 or 30%,	Retail: the greater of $25 or 30% Mail: the greater of $50 or 30%,	
	Specialty drugs	Retail: the greater of $15 or 20%, $75 max. Mail: the greater of $30 or 20%, $150 maximum	Retail: the greater of $15 or 20%, $75 max. Mail: the greater of $30 or 20%, $150 maximum	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance outside of Anchorage	Alaska Regional Medical Center in Anchorage and Mat-Su Regional Medical Center are the preferred provider hospitals.in Anchorage. Coinsurance is 30% if you use a non-ppo hospital in Anchorage
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	————————none————————
	Emergency medical transportation	20% coinsurance	20% coinsurance	————————none————————
	Urgent care	20% coinsurance	20% coinsurance	Coinsurance is 30% if you use a non PPO hospital in Anchorage.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance outside of Anchorage	Precertification is required, failure to precertify may result in no benefits paid for hospital charges if it is determined that an inpatient stay was not medically necessary. Coinsurance is 30% if you use a non PPO hospital in Anchorage.
	Physician/surgeon fee	20% coinsurance	20% coinsurance	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	————————none————————
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance outside of Anchorage	Precertification is required, failure to precertify may result in no benefits paid for hospital charges if it is determined that an inpatient stay was not medically necessary. Coinsurance is 30% if you use a non PPO hospital in Anchorage.
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	————————none————————
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance outside of Anchorage	Precertification is required, failure to precertify may result in no benefits paid for hospital charges if it is determined that an inpatient stay was not medically necessary. Coinsurance is 30% if you use a non PPO hospital in Anchorage.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	No coverage for a dependent child or child of a dependent child. Precertification is required for stays in excess of 48 hours for normal delivery or 96 hours cesarean section. Failure to precertify may result in no benefits paid for hospital charges Coinsurance is 30% if you use a non-PPO hospital in Anchorage.
	Delivery and all inpatient services	20% coinsurance	20% coinsurance outside of Anchorage	

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Limited to 100 visits per year.
	Rehabilitation services	20% coinsurance	20% coinsurance	——————none——————
	Habilitation services	100% coinsurance	100% coinsurance	Habilitation services are not covered.
	Skilled nursing care	No charge	No charge	Limited to 100 days during a disability.
	Durable medical equipment	20% coinsurance	20% coinsurance	——————none——————
	Hospice service	20% coinsurance	20% coinsurance	Limited to 30 inpatient days per year.
If your child needs dental or eye care	Eye exam	$25 copay	Fees in excess of $45	Limited to one exam per year.
	Glasses	$35 copay	Fees in excess of $45 for single vision lenses and fees in excess of $47 for frames	Limited to one pair of glasses every 24 months.
	Dental check-up	20% coinsurance	20% coinsurance	Limited to 1 dental exam once every 6 months.

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.)

- Acupuncture (unless performed by a MD or DO and is medically necessary)
- Bariatric surgery
- Cosmetic surgery (except as necessary for the repair of an accidental bodily injury)
- Hearing aids
- Habilitation services
- Infertility treatment
- Long-term care
- Marital or family counseling
- Massage therapist
- 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.)

- Chiropractic care (limited to 24 visits per year)
- Dental care (adult)
- Non-emergency care when traveling outside the U.S. which is medically necessary and standard of care in the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care

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 **1-800-478-8329** (Select Option 4). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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: www.akufcwtrust.com or by calling 1-800-478-8329 (Select Option 1). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform for additional information.

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. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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** $5,730
- **Patient pays** $1,810

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	$250
Copays	$10
Coinsurance	$1,400
Limits or exclusions	$150
Total	**$1,810**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,430
- **Patient pays** $970

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	$250
Copays	$200
Coinsurance	$440
Limits or exclusions	$80
Total	**$970**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.