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, www.aetf.com or call 800-478-1246. 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 www.aetf.com or call 800-478-1246 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$600/individual or $1,800/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 $2,600/ individual, $5,200/family, then 90% up to $5,200/individual, $10,400/ 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 www.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
		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. Teladoc consultations are covered at 100%.
	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. Full coverage if required by federal law.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance to the first $50,000 of the allowed amount if in Anchorage area or outside Alaska, otherwise 20% of the allowed amount.	Full coverage if required by federal law.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance to the first $50,000 of the allowed amount if in Anchorage area or outside Alaska, otherwise 20% 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
		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.aetf.com	Formulary 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). Name-brand drugs not covered if generic is available. Formulary exclusions not covered. For prescription drugs, $750/person and $1,500/family per calendar year out-of-pocket maximum. Nonspecialty drugs exceeding $1,500 will be reviewed by Consultant Pharmacist.
	Formulary Preferred brand drugs	If generic is not available: Retail: $35 copayment Mail order: $70 copayment Not covered if generic is available		
	Non-Formulary, Non-preferred brand drugs	If generic is not available: Retail: $50 copayment Mail order: $100 copayment		
	Specialty drugs	Generic: $15 copayment; Formulary Preferred brand drugs: $35copayment ; Non-formulary, Nonpreferred brand drugs: $50 copayment		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance applied to the first $50,000of the allowed amount if in Anchorage area or outside Alaska, otherwise 20% of the allowed amount.	Preauthorization required for some procedures. 50% reduction in facility charges for an out-of-network provider. In some instances, services provided by an out-of-network provider at an in-network facility may be payable at 20% coinsurance.
	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

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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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance applied to the first $50,000 of the allowed amount if in Anchorage area or outside Alaska plus a $1,000 penalty, otherwise 20% coinsurance of the allowed amount	Preauthorization required. In some instances, services provided by an out-of-network provider at an in-network facility may be payable at the in-network coinsurance.
	Physician/surgeon fees	20% coinsurance of the allowed amount		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance of the allowed amount		Preauthorization required for some services.
	Inpatient services	20% coinsurance	40% coinsurance applied to the first $50,000 of the allowed amount if in Anchorage area or outside Alaska plus a $1,000 penalty, otherwise 20% coinsurance of the allowed amount.	Preauthorization required. In some instances, services provided by an out-of-network provider at an in-network facility may be payable at the in-network coinsurance.
	Substance use disorder outpatient services	20% coinsurance of the allowed amount		None
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance applied to the first $50,000 of the allowed amount if in Anchorage area or outside Alaska plus a $1,000 penalty, otherwise 20% coinsurance of the allowed amount.	Preauthorization required. In some instances, services provided by an out-of-network provider at an in-network facility may be payable at the in-network coinsurance
If you are pregnant	Office visits	20% coinsurance of the allowed amount.		Cost sharing does not apply to certain preventive services. Coinsurance may apply for some services. Maternity care may include tests and services described in the SBC (i.e. ultrasound).

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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 are pregnant	Childbirth/delivery professional services	20% coinsurance of the allowed amount.	Preauthorization required for stays beyond 48 hours (vaginal delivery), 96 hours (Cesarean). In some instances, services provided by an out-of-network provider at an in-network facility may be payable at the in-network coinsurance.	Childbirth/delivery professional services
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance applied to the first $50,000 of the allowed amount if in Anchorage area or outside Alaska plus a $1,000 penalty, otherwise 20% coinsurance of the allowed amount.	Preauthorization required for stays beyond 48 hours (vaginal delivery), 96 hours (Cesarean). In some instances, services provided by an out-of-network provider at an in-network facility may be payable at the in-network coinsurance.
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	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. 25 visits per 12-month period.
	Habilitation services			
	Skilled nursing care	20% coinsurance	20% coinsurance of the allowed amount.	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	Children's dental check-	Not covered.	Not covered.	See SBC for dental plans.

dental or eye care	up			
	Children's eye exam	Not covered.	Not covered.	See SBC for vision plans.
	Children's glasses	Not covered.	Not covered.	See SBC for vision plans.
	Children's dental check-up	Not covered.	Not covered.	See SBC for dental plans.

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
- Teledoc visits
- Chronic condition care program
- Dental care (Adult)
- Hearing aids ($2,500/ear every 36 months)
- Promotion of conception treatment (Up to a lifetime maximum of $12,000)
- Minor care clinics
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Medical travel

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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

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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 *cost sharing*	**20%**
Hospital (facility) *cost sharing*	**$300+20%**
Other *cost sharing*	**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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$310
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,270**

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 *cost sharing*	**20%**
Hospital (facility) *cost sharing*	**$300+20%**
Other *cost sharing*	**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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$100
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$600**
Specialist *cost sharing*	**20%**
Hospital (facility) *cost sharing*	**$300+20%**
Other *cost sharing*	**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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$110
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,110**

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

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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 , 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:

Administrative Office
701 E Tudor Suite 200
Anchorage, AK 99503

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Important Questions	Answers						Why This Matters:
Plan Name	601	602	603	604	605	606	
What is the overall deductible?	$0	$25/person & $75/ family			$50/person & $150/ family	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No						You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.						You don't have to meet deductibles for specific services.
What is not included in the out-of-pocket limit?	Not Applicable						This plan does not have an out–of–pocket limit on your expenses.
What is the out-of-pocket limit for this plan?	Not Applicable						This plan does not have an out–of–pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	$2,000	$2,000	$1,500	$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.
	These limits do not apply to dependent children under age 19						
Will you pay less if you use a network provider?	Not Applicable						This plan does not use a provider network.
Do you need a referral to see a specialist?	No						You can see the specialist you choose without a referral.

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Common Medical Event	Services You May Need	What You Will Pay (Coinsurance)						Limitations, Exceptions, & Other Important Information
		601	602	603	604	605	606	
If your child needs dental care	Dental checkup	10%	None	30%	30%	40%	60%	Annual maximums applicable to dependents age 19 & older: Plans 601, 602 – $2,000 Plans 603, 604 and 606 – $1,500 Plan 605 – $1,000

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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 services covered before you meet your deductible?	Not Applicable				You do not have to meet the deductible before the plan pays for any services. but see the chart starting on page 2 for other 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.
What is the out-of-pocket limit for this plan?	Not Applicable				This plan does not have an out–of–pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable				This plan does not have an out–of–pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See https://www.vsp.com/ or call 1-800-877-7195 for a list of 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.

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Common Medical Event	Services You May Need	What You Will Pay					Limitations, Exceptions, & Other Important Information
		701 (VSP)	702 (VSP)	703 (VSP)	704 (VSP)	Out-of-Network Provider (You will pay the most)	
If your child needs eye care	Eye exam	$10/person copayment	$20/person copayment			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: copayment	$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	

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.)

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

- Contact lenses
- Routine eye care (Adult)

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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, 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:

Administrative Office
701 E Tudor Suite 200
Anchorage, AK 99503