

 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, go to [www.meritain.com](http://www.meritain.com) or call (907) 624-3611. 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 Meritain Health, Inc. at (866) 808-2609 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	For participating & non-participating <u>providers</u> : \$300 person / \$625 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. For participating & non-participating <u>providers</u> : <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. \$5,000 for transplants (if you don't get <u>preauthorization</u> )	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	For participating & non-participating <u>providers</u> : \$195 person For non-participating hospitals in Anchorage: Unlimited	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>prescription drug copays</u> , <u>deductibles</u> , <u>coinsurance</u> for Anchorage non-participating hospitals, <u>preauthorization</u> penalty amounts, <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain">www.aetna.com/docfind/custom/mymeritain</a> or call (800) 343-3140 or <a href="http://www.tappn.com">www.tappn.com</a> or call (866) 808-2609 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	10% <u>coinsurance</u>	There is no charge and the <u>deductible</u> does not apply if you receive telephone consultation services through the Teladoc program.
	<u>Specialist</u> visit	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
	<u>Preventive care/ screening/ immunization</u>	No Charge	No Charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Routine pap smears, physical exams, prostate exams are limited to 1 per year each. Routine colonoscopy limited to 1 every 5 years.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	10% <u>coinsurance</u> (facilities outside Anchorage & all professional fees) / 40% <u>coinsurance</u> (facilities in Anchorage)	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	10% <u>coinsurance</u> (facilities outside Anchorage & all professional fees) / 40% <u>coinsurance</u> (facilities in Anchorage)	<u>Preauthorization</u> required for PET scans and non-orthopedic CT/MRI's. If you don't get <u>preauthorization</u> , benefits could be reduced by \$750 of the total cost of the service.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	10% <u>copay</u> (retail & mail order)	10% <u>coinsurance</u> (retail)	<u>Deductible</u> does not apply to participating pharmacies. Covers up to a 180-day supply (retail prescription); 180-day supply (mail order prescription). The <u>copay</u> applies per prescription. <u>Major medical deductible &amp; coinsurance</u> will apply to <u>prescription drugs</u> obtained from a non-participating pharmacy. <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.
	Brand name drugs	10% <u>copay</u> (retail & mail order)	10% <u>coinsurance</u> (retail)	
	<u>Specialty drugs</u>	10% <u>copay</u> (retail & mail order)	10% <u>coinsurance</u> (retail)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Preauthorization required for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. If you don't get preauthorization, benefits could be reduced by \$750 of the total cost of the service. There is no charge and the deductible does not apply for certain surgical procedures received through Bridgehealth. See your plan document for a detailed listing.
	Physician/surgeon fees	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u> (non-emergency services in Anchorage) / 10% <u>coinsurance</u> (all other emergency room care)	Non-participating providers paid at the participating provider level of benefits for emergency services.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----none-----
	<u>Urgent care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	10% <u>coinsurance</u> (outside Anchorage) / 40% <u>coinsurance</u> (in Anchorage)	Preauthorization required. If you don't get preauthorization, benefits could be reduced by \$750 of the total cost of the service.
	Physician/surgeon fees	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u> (facilities outside Anchorage & all professional fees) / 40% <u>coinsurance</u> (facilities in Anchorage)	-----none-----
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u> (facilities outside Anchorage & all professional fees) / 40% <u>coinsurance</u> (facilities in Anchorage)	Preauthorization required. If you don't get preauthorization, benefits could be reduced by \$750 of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Office visits	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<p><u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get <u>preauthorization</u>, benefits could be reduced by \$750 of the total cost of the service. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family <u>deductible</u> amount may apply.</p>
	Childbirth/delivery professional services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	10% <u>coinsurance</u> (outside Anchorage) / 40% <u>coinsurance</u> (in Anchorage)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Limited to 130 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$750 of the total cost of the service.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Includes occupational therapy. Physical & speech therapy limited to a 60 visits per each type of therapy per year. <u>Preauthorization</u> required for inpatient services. If you don't get <u>preauthorization</u> , benefits could be reduced by \$750 of the total cost of the service.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Limited to 90 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$750 of the total cost of the service.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Preauthorization</u> required for electric/motorized scooters or wheelchairs and pneumatic compression devices. If you don't get <u>preauthorization</u> , benefits could be reduced by \$750 of the total cost of the service. Limited to a \$5,000 maximum per rental up to purchase price.
	<u>Hospice services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Bereavement counseling is covered.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's glasses	Not Covered	Not Covered	Covered under stand alone vision plan.
	Children's dental check-up	Not Covered	Not Covered	Covered under stand alone dental plan.

**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.)**

- Bariatric surgery
- Cosmetic surgery
- Dental care (covered under stand alone dental plan)
- Glasses (covered under stand alone vision plan)
- Non-emergency care when traveling outside the U.S. (except for services by BridgeHealth, Inc.)
- Infertility treatment
- Long-term care
- Routine eye care (covered under stand alone vision plan)
- 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
- Chiropractic care
- Hearing aids
- Private-duty nursing

**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: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), or Bering Strait School District at (907) 624-3611. 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](http://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 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 Bering Strait School District at (907) 624-3611 or Meritain Health, Inc. at (866) 808-2609.

**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:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-378-1179.

---

*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 \$300
- Primary care physician coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Primary care physician visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

**Total Example Cost** \$12,840

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$238
Copayments	\$0
Coinsurance	\$261
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$559</b>

**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$300
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Specialist office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

**Total Example Cost** \$7,460

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$621
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$976</b>

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

- The plan's overall deductible \$300
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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** \$2,010

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$193
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$493</b>