**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 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: |
|---|---|---|
| **What is the overall deductible?** | For participating & non-participating providers: $800 person / $1,600 family | Generally, you must pay all of the 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. For participating providers: Preventive care and the first 3 office visits of the year (all providers) are 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For participating providers: $6,000 person / $12,000 family For non-participating providers: Unlimited person & family | The out-of-pocket limit is the most you could pay in a year for covered services. 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?** | Premiums, preauthorization penalty amounts, balance-billing 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. |
| **Will you pay less if you use a network provider?** | Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 or www.tappn.com or call (866) 808-2609 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. |

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) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copay/visit (1st 3 office visits of the year) / 10% coinsurance (subsequent visits & office surgery) | $25 copay/visit (1st 3 office visits of the year) / 30% coinsurance (subsequent visits & office surgery) | Copay applies per visit regardless of what services are rendered, excluding office surgery. The first 3 office visits of the year are combined with mental health/ substance use office visits. |
| | Specialist visit | $25 copay/visit (1st 3 office visits of the year) / 10% coinsurance (subsequent visits & office surgery) | $25 copay/visit (1st 3 office visits of the year) / 30% coinsurance (subsequent visits & office surgery) | |
| | Preventive care/screening/ immunization | No Charge | 30% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | Preauthorization required. If you don't get preauthorization, benefits could be reduced by $750 of the total cost of the service. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.express-scripts.com | Generic drugs | 20% copay (retail & mail order) | 20% copay (retail) | Deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). The copay applies per prescription. There is no charge for preventive drugs. Mandatory generic provision applies. Specialty drugs must be obtained directly from the specialty pharmacy program after one fill at a retail pharmacy. |
| | Brand name drugs | 20% copay (retail & mail order) | 20% copay (retail) | |
| | Specialty drugs | 20% copay (retail & mail order) | 20% copay (retail) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | Preauthorization required. 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 plan for details. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | |

| 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 need immediate medical attention** | Emergency room care | 10% coinsurance (emergency services) / $100 copay, then 10% coinsurance (non-emergency services) | 10% coinsurance (emergency services) / $100 copay, then 30% coinsurance (non-emergency services) | Non-participating providers paid at the participating provider level of benefits for emergency services. Copay is waived if admitted to the hospital. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | Non-participating providers paid at the participating provider level of benefits. |
| | Urgent care | 10% coinsurance | 30% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | 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% coinsurance | 30% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit (1st 3 office visits per year) / 10% coinsurance (subsequent visits) / 10% coinsurance (all other outpatient services) | $25 copay/visit (1st 3 office visits per year) / 30% coinsurance (subsequent visits) / 30% coinsurance (all other outpatient services) | The first 3 office visits of the year are combined with primary care provider and specialist office visits. |
| | Inpatient services | 10% coinsurance | 30% coinsurance | Preauthorization required. If you don't get preauthorization, benefits could be reduced by $750 of the total cost of the service. |
| **If you are pregnant** | Office visits | 10% coinsurance | 30% coinsurance | Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by $750 of the total cost of the service. Cost sharing does not apply to preventive services from a participating provider. 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 deductible amount may apply. |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | |

| 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 need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance | Limited to 130 visits per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $750 of the total cost of the service. |
| | Rehabilitation services | 10% coinsurance | 30% coinsurance | Physical, speech, occupational, massage & neurodevelopmental therapy, chronic pain care, cardiac & pulmonary rehabilitation limited to a combined maximum of 45 visits per year for outpatient services. Inpatient services limited to 30 days per year. |
| | Habilitation services | 10% coinsurance | 30% coinsurance | |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | Limited to 60 days per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by $750 of the total cost of the service. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | Preauthorization required for any item in excess of $1,000. If you don't get preauthorization, benefits could be reduced by $750 of the total cost of the service. |
| | Hospice services | 10% coinsurance | 10% coinsurance | Outpatient hospice services limited to 130 visits per year. Inpatient hospice services limited to 10 days per year. Respite care limited to 240 hours per year. Bereavement counseling is covered if received within 6 months of death. |
| **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 | |
| | 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)**
- **Infertility treatment**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S. (except for services by BridgeHealth, Inc.)**
- **Routine eye care (covered under stand alone vision plan)**
- **Routine foot care (except for metabolic or peripheral vascular disease)**
- **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, 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 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, kwiijigo 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** | **$800** |
| **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $0 |
| Coinsurance | $1,267 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $2,127 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$800** |
| **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $0 |
| Coinsurance | $1,144 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | $1,999 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$800** |
| **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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $0 |
| Coinsurance | $268 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1,068 |

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