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.meritain.com** or by calling your employer at **(907) 624-3611** or Meritain Health, Inc. at **(866) 808-2609**.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	For PPO & non-PPO **providers** **$75** person / **$225** family (Individual deductible applies only for individual coverage.)	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. **$5,000** for transplants (unless pre-authorized). 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.
Is there an **out-of-pocket limit** on my expenses?	Yes. For PPO & non-PPO **providers**: **$195** person; Anchorage hospital non-PPO: **Unlimited**	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**?	Copays, deductibles, premiums, precertification penalty amounts, coinsurance for Anchorage non-PPO hospitals, 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 *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a **network** of **providers**?	Yes. See **www.aetna.com/docfind/custom/mymeritain** or **www.tappn.com** or call **(800) 343-3140 or (866) 808-2609** for a list of PPO **providers**.	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**.

- **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 a non-PPO **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-PPO **provider** 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 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 an illness	10% coinsurance	10% coinsurance	No charge & deductible does not apply for second surgical opinions.
	Specialist visit	10% coinsurance	10% coinsurance	
	Other practitioner office visit	10% coinsurance for chiropractor and acupuncture	10% coinsurance for chiropractor and acupuncture	Maximum calendar year benefit of 20 visits for chiropractic care.
	Preventive care/ screening/ immunization	No Charge	No Charge	Deductible does not apply. Services covered: Annual Physical, Well Baby/Child exams, Routine Pap, Routine Mammogram, Routine Prostate Exam, Routine Colonoscopy, Immunizations (see plan document for limits.)
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	10% coinsurance (40% coinsurance for non-PPO hospitals in Anchorage)	----------none----------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance (40% coinsurance for non-PPO hospitals in Anchorage)	Precertification required. Failure to precertify will result in a $750 penalty
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	10% coinsurance	10% coinsurance	The deductible does not apply for PPO providers. Covers up to a 180-day supply (retail prescription); 180-day supply (mail order prescription). For non-PPO providers, you pay the cost of the drug and submit for reimbursement directly to Meritain health. Major medical deductible & coinsurance will apply for non-ppo providers.
	Brand name drugs	10% coinsurance	10% coinsurance	
	Specialty drugs	10% coinsurance	10% coinsurance	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	Precertification required. Failure to precertify will result in a $750 penalty. Certain surgical procedures are covered at 100% (deductible waived) when they are received through the BridgeHealth Surgery Benefit Option. Not all surgical procedures are eligible for coverage under this option. Please refer to the BridgeHealth Surgery Benefit Option for a more detailed description of this benefit.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	
If you need immediate medical attention	Emergency room services	10% coinsurance (medical emergency)/ 10% coinsurance (non-medical emergency)	10% coinsurance (medical emergency)/ 10% coinsurance (non-PPO outside Anchorage / 40% coinsurance (non-PPO in Anchorage) (non-medical emergency)	Precertification required if admitted to hospital. Failure to precertify will result in a $750 penalty.
	Emergency medical transportation	10% coinsurance	10% coinsurance	----------none----------
	Urgent Care	10% coinsurance	10% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance (non-PPO outside Anchorage)/ 40% coinsurance (non-PPO in Anchorage)	Precertification required. Failure to precertify will result in a $750 penalty.
	Physician/surgeon fee	10% coinsurance	10% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	40% coinsurance (non-PPO hospital in Anchorage) / 10% coinsurance (all other locations)	----------none----------
	Mental/Behavioral health inpatient services	10% coinsurance	40% coinsurance (non-PPO in hospital Anchorage) / 10% coinsurance (all other locations)	Precertification required. Failure to precertify will result in a $750 penalty.

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
	Substance use disorder outpatient services	10% coinsurance	40% coinsurance (non-PPO hospital in Anchorage) / 10% coinsurance (all other locations)	----------none----------
	Substance use disorder inpatient services	10% coinsurance	40% coinsurance (non-PPO hospital in Anchorage) / 10% coinsurance (all other locations)	Precertification required. Failure to precertify will result in a $750 penalty.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	10% coinsurance	----------none----------
	Delivery and all inpatient services	10% coinsurance	Facility: 10% coinsurance (non-PPO outside Anchorage) / 40% coinsurance (non-PPO in Anchorage) Physician: 10% coinsurance	Precertification required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Failure to precertify will result in a $750 penalty. Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	Limited to 130 visits per year. Precertification required. Failure to precertify will result in a $750 penalty.
	Rehabilitation services	10% coinsurance	10% coinsurance	Includes physical, speech & occupational therapy. 60 visit calendar year maximum for physical & speech therapy (60 visits each).
	Habilitation services	10% coinsurance	10% coinsurance	----------none----------
	Skilled nursing care	10% coinsurance	10% coinsurance	Limited to 90 days per year. Precertification required. Failure to precertify will result in a $750 penalty.
	Durable medical equipment	10% coinsurance	10% coinsurance	Precertification required for any item in excess of $1,000. Failure to precertify will result in a $750 penalty. $5,000 maximum per rental up to purchase price.

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
	Hospice service	10% coinsurance	10% coinsurance	Bereavement counseling is only covered if received within 6 months of death.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Covered under stand alone vision plan.
	Glasses	Not Covered	Not Covered	Covered under stand alone vision plan.
	Dental check-up	Not Covered	Not Covered	Covered under stand alone dental plan.

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.)

- **Bariatric surgery**
- **Cosmetic surgery**
- **Dental care (covered under stand alone dental plan)**
- **Glasses (covered under stand alone vision plan)**
- **Infertility treatment (except diagnosis)**
- **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**
- **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**
- **Chiropractic care**
- **Hearing aids**
- **Private-duty nursing**

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) 624-3611 or Meritain Health, Inc. at (866) 808-2609. 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 Bering Strait School District at (907) 624-3611 or Meritain Health, Inc. at (866) 808-2609.

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.**

Language Access Services:

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

(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.

(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 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 $6,970**
- **Patient pays $570**

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	$225
Copays	$0
Coinsurance	$195
Limits or exclusions	$150
Total	**$570**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,900**
- **Patient pays $500**

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	$225
Copays	$0
Coinsurance	$195
Limits or exclusions	$80
Total	**$500**

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.
- Coverage examples are based on single coverage only.
- 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 PPO **providers**. If the patient had received care from non-PPO **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.