

 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) 228-6613. 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 and non-participating <u>providers</u> : \$350 person / \$1,050 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> , <u>home health care</u> , <u>skilled nursing care</u> and office visit charges for the 1 st 6 visits per year 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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For participating <u>providers</u> , non-participating <u>providers</u> and participating <u>provider</u> facilities: \$1,500 person / \$4,500 family For non-participating <u>provider</u> facilities: 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.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>coinsurance</u> for non-participating hospital charges, amounts in excess of Medicare/CMS rural rate for air <u>emergency medical transportation</u> , <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> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 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.

Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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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 <u>copay</u> /visit (1 st 6 office visits per year)/ 20% <u>coinsurance</u> (all other visits and services)	\$25 <u>copay</u> /visit (1 st 6 office visits per year)/ 20% <u>coinsurance</u> (all other visits and services)	<u>Copay</u> applies to the physician office visit only. Includes telemedicine consultations. There is no charge and the <u>deductible</u> does not apply if you receive general medical consultation services through Teladoc.
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit (1 st 6 office visits per year)/ 20% <u>coinsurance</u> (all other visits and services)	\$25 <u>copay</u> /visit (1 st 6 office visits per year)/ 20% <u>coinsurance</u> (all other visits and services)	
	<u>Preventive care/screening</u> immunization	No Charge	No Charge	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For non-participating facility charges, you pay 40% <u>coinsurance</u> & your benefits are never paid at 100%. There is no charge or <u>deductible</u> for pre-admission testing.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Major medical <u>deductible</u> applies. Covers up to a 90-day supply (retail & mail order prescription). There is no charge or <u>deductible</u> for preventive drugs.
	Brand drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	For non-participating facility charges, you pay 40% <u>coinsurance</u> & your benefits are never paid at 100%. There is no charge or <u>deductible</u> for services received from BridgeHealth, Inc.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	

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	<u>Emergency room care</u>	\$100 <u>copay</u> /visit, then 20% <u>coinsurance</u>	\$100 <u>copay</u> /visit, then 20% <u>coinsurance</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits. <u>Copay</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For air <u>emergency medical transportation</u> , allowable charges subject to 80% of the following Medicare/CMS rural rates: 350% of the Medicare/CMS rate (1 way transport); 600% of the Medicare/CMS rural rate (fixed wing air mileage per statute mile); 200% of Medicare/CMS rural rate (rotary wing air mileage, per statute mile).
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service. For non-participating facility charges, your benefits are never paid at 100%.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For non-participating facility charges, you pay 40% <u>coinsurance</u> & your benefits are never paid at 100%.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service. For non-participating facility charges, your benefits are never paid at 100%.

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	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<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 \$250 of the total cost of the service. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating <u>provider</u> . 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. For non-participating facility charges, you pay 40% <u>coinsurance</u> & your benefits are never paid at 100%.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	No Charge (birthing center) /20% <u>coinsurance</u> (all other facilities)	No Charge (birthing center) /20% <u>coinsurance</u> (all other facilities)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	No Charge	-----none-----
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Includes physical, hearing, speech & occupational therapy. For non-participating facility charges, you pay 40% <u>coinsurance</u> & your benefits are never paid at 100%.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	<u>Skilled nursing care</u>	No Charge	No Charge	Limited to 90 days per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Advance written approval required for any item in excess of \$1,000.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Bereavement counseling is not covered. Inpatient and outpatient services limited to combined 180 days per lifetime.
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.)

- Bereavement counseling
- Cosmetic surgery (except correction of congenital defects of newborn or correction of defects incurred through traumatic injuries)
- 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)

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

- Acupuncture
- Bariatric surgery (for the treatment of morbid obesity only)
- Chiropractic care
- Hearing aids
- Private-duty nursing
- Weight loss programs (for the treatment of morbid obesity only)

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 Ketchikan Gateway Borough & School District at (907) 228-6649. 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 Ketchikan Gateway Borough & School District at (907) 228-6649 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): Dinekehgo 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 \$350
- Primary care physician coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$0
Coinsurance	\$1,150
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,560

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

- The plan's overall deductible \$350
- Specialist copayment \$25
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$225
Coinsurance	\$925
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,555

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

- The plan's overall deductible \$350
- Specialist copayment \$25
- Hospital (facility) coinsurance 20%
- Other coinsurance 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	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$175
Coinsurance	\$272
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$797