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 **907-228-6613** or Meritain Health, Inc. at **866-808-2609**.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	For PPO & non-PPO **providers** **$50** person / **$150** family	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. **$50** person/ **$150** family for dental services. 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 **providers,** Non-PPO **providers** & PPO **provider** facilities: **$850** person For Non-PPO **provider** facilities: **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**?	Pre-certification penalties, coinsurance for non-PPO hospital charges, amounts in excess of Medicare/CMS rural rate for Guardian Flight, premiums, dental and vision charges, 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 any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See **www.aetna.com/docfind/custom/mymeritain** or call **800-343-3140** 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**.

Questions: Call your employer at **907-228-6613** or Meritain Health, Inc. at **866-808-2609** or visit us at **www.meritain.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call your employer at **907-228-6613** to request a copy.

- **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	20% coinsurance	20% coinsurance	There is no charge and the deductible does not apply if you receive telephone consultation services through the telemedicine program.
	Specialist visit	20% coinsurance	20% coinsurance	
	Other practitioner office visit	20% coinsurance for chiropractor and acupuncture	20% coinsurance for chiropractor and acupuncture	Acupuncture included in alternative care benefit (limited to 12 visits per year).
	Preventive care/ screening/immunization	20% coinsurance	20% coinsurance	Deductible does not apply. Includes routine colonoscopy, physical exams & related testing, immunizations, routine pap smear, prostate exam, well baby exams and mammograms. For routine hearing exams (1 per year), there is no charge or deductible. Refer to your plan document for limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	For non-PPO hospital charges, you pay 40% coinsurance & your benefits are never paid at 100%. There is no charge or deductible for pre-admission testing.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition.	Generic drugs	20% coinsurance	20% coinsurance	The deductible does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription).

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
More information about **prescription drug coverage** is available at www.express-scripts.com	Brand name drugs	20% coinsurance	20% coinsurance	
	Specialty drugs	20% coinsurance	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	For non-PPO hospital charges, your benefits are never paid at 100%. There is no charge or deductible for services received from BridgeHealth, Inc.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room services	$100 copay/visit + 20% coinsurance	$100 copay/visit + 20% coinsurance	Copay waived if you are admitted to hospital. Non-PPO providers paid at the PPO provider level of benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	For Guardian Flight (air ambulance), 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 statue mile); 200% of Medicare/CMS Rural Rate (rotary wing air mileage, per statue mile).
	Urgent Care	20% coinsurance	20% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification required. Failure to precertify will result in a $250 penalty. For non-PPO hospital charges, your benefits are never paid at 100%.
	Physician/surgeon fee	20% coinsurance	20% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	For non-PPO hospital charges, you pay 40% coinsurance & your benefits are never paid at 100%.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Precertification required. Failure to precertify will result in a $250 penalty. For non-PPO hospital charges, your benefits are never paid at 100%.
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	For non-PPO hospital charges, you pay 40% coinsurance & your benefits are never paid at 100%.

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 inpatient services	20% coinsurance	40% coinsurance	Precertification required. Failure to precertify will result in a $250 penalty. For non-PPO hospital charges, your benefits are never paid at 100%.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	For non-PPO hospital charges, you pay 40% coinsurance & your benefits are never paid at 100%.
	Delivery and all inpatient services	20% coinsurance (hospital) / No charge (birthing center)	20% coinsurance (hospital) / No charge (birthing center)	Deductible does not apply for birthing center charges. 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 $250 penalty. Baby does not count toward the mother's expense; therefore the family deductible amount may apply. For non-PPO hospital charges, you pay 40% coinsurance & your benefits are never paid at 100%. There is no charge or deductible for birthing center charges.
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Deductible does not apply.
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes physical, speech, hearing & occupational therapy. For non-PPO hospital charges, you pay 40% coinsurance & your benefits are never paid at 100%.
	Habilitation services	20% coinsurance	20% coinsurance	----------none----------
	Skilled nursing care	No Charge	No Charge	Limited to 90 days per year. Deductible does not apply. Precertification required. Failure to precertify will result in a $250 penalty.
	Durable medical equipment	20% coinsurance	20% coinsurance	Advance written approval required for any item in excess of $1,000.
	Hospice service	20% coinsurance	20% coinsurance	Bereavement counseling is not covered. Limited to 180 days (lifetime maximum).

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 your child needs dental or eye care	Eye exam	20% coinsurance	20% coinsurance	Deductible does not apply. Limited to 1 exam per year.
	Glasses	20% coinsurance	20% coinsurance	Deductible does not apply. Limited to 1 pair lenses per year & 1 pair frames every 2 years.
	Dental check-up	No Charge	No Charge	Deductible does not apply.

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.)

- **Bereavement counseling**
- **Cosmetic surgery (except correction of congenital defects of newborn or correction of defects incurred through traumatic injuries)**
- **Infertility treatment**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S. (except for services by BridgeHealth, Inc.)**
- **Routine foot care**

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**
- **Bariatric surgery (for the treatment of morbid obesity only)**
- **Chiropractic care**
- **Dental care (adult & child)**
- **Glasses (Adult & Child)**
- **Hearing aids**
- **Private-duty nursing (covered under skilled nursing benefit only)**
- **Routine eye care (adult & child)**
- **Weight loss programs (for the treatment of morbid obesity only)**

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 907-228-6613 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 Ketchikan Gateway Borough & School District at 907-228-6613, Meritain Health, Inc. at 866-808-2609 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 $6,490**
- **Patient pays $1,050**

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	$100
Copays	$0
Coinsurance	$800
Limits or exclusions	$150
Total	**$1,050**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,470**
- **Patient pays $930**

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	$50
Copays	$0
Coinsurance	$800
Limits or exclusions	$80
Total	**$930**

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.