



Ketchikan Gateway Borough

A Guide to Your Benefits and Enrollment



**Bring Healthy Balance
Back to Your Life**

Finding your perfect balance.

A balanced life means a healthier *you*.

At Meritain Health, we know how important it is for you to understand how your benefits work.

This packet contains:

- **Useful information about your benefits plan.**
- **Everything you need to choose the best options for you and your family.**
- **Step-by-step instructions on how to enroll, and to begin using your new benefits.**

Why do we feel this is important? Because, let's face it, living today can be larger than life. Getting through the day at top speed is a sign of our hurry-up, drive-through times. Many people put themselves at the bottom of their "to-do" lists, giving everything else the best of their energy.

In this way, life gets out of balance. Most of us can keep juggling it all until one day health and well-being begin to pay the price.

Take a deep breath, step back and see the big picture. Help yourself. Put that life on "pause" for a few minutes, and take the time to read this packet. You'll see that your employer provides tools, resources and benefits to help you regain your best life and make smart healthcare decisions.

We want to help you get the most from your benefits—so you can live a life that's balanced and informed.

A balanced life means a *healthier you*.



What's Inside?

In this packet, learn more about:

Preventive care.

- Annual exams and check-ups
- Well-child care
- Immunizations and screenings

Healthcare benefits when you're sick.

- Inpatient and outpatient care
- Home healthcare
- Rehabilitation services
- Doctor visits and prescription drugs with reasonable copays
- Mail order and online prescription options
- A large and convenient provider network
- Dental care
- Vision care

Support when you need it.

- www.myMERITAIN.com: Access easy-to-use decision support tools that help you weigh your care options, and provide cost and quality information.

Other benefits to help restore and protect peace of mind.

- Life and AD&D insurance plans: Benefits for you, to protect those you love.



No Surprises, Just Information

Important things to know about eligibility.

Health plans are put together carefully to provide the best benefits possible for participants. Meritain Health knows how important it is for healthcare consumers like you to really understand how your plan works. In this way, you can make the changes you want in your health and in your life. The next section of this packet describes some of the most important provisions of your benefits. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed, with no “surprises.”

Healthy balance for your family, too.

Your family members can reap the rewards of the plan, too. Healthcare benefits are available for every eligible dependent. It's a great way to help your family members find the right balance between life's “roller-coaster ride” and their best health. Be sure your family knows about the opportunities open to them—share this packet and other materials you receive from the plan!

Your eligible dependents.

This benefit plan is open to you and your eligible dependents.

An eligible dependent is:

- Your spouse (as defined in your plan documents).
- Your children, natural or adopted.
- Stepchildren living in your home.
- Children who have been placed in your home for adoption.
- Children for whom you are the legal guardian.

Please refer to your summary plan description for specific requirements.

When your dependents are not eligible for benefits under your plan.

Tell your employer if:

- You become divorced from a spouse who was covered under this plan.
- A dependent is between the ages of 19-23 and is not a full-time student.
- A dependent turns 23 years old.

To enroll the dependent for COBRA—a special limited-time plan for continuing benefits at your own expense—you must notify your employer within 60 days of that person's change in dependent status.

If you have a family member covered by a different plan.

- You can enroll yourself and your eligible dependents in this plan.
- You can enroll yourself in this plan, but decline benefits for some or all dependent(s).
- You can decline benefits for your whole family.

In this section:

- Health benefits for your family
- Enrolling at a later date
- Special enrollment situations
- If your spouse already has coverage
- Pre-existing condition limitations
- Creditable coverage

Age limits for children's benefits.

- Usually, children are eligible for benefits until they turn 19.
- If they're enrolled as full-time students, they remain eligible until they turn 23.

You'll have to provide proof now to enroll any student over age 19, and again for each semester of school. The proof may be a letter from the registrar's office, a copy of a receipt, or other proof of tuition payment that includes the number of credits or shows full-time student status.

When you have benefits from two group plans.

If you or one of your dependents have benefits under both this plan and another plan, the two plans will coordinate your benefits. One plan will be considered the primary plan (or first payer) and the other will be the secondary plan (pays only after the first plan has paid).

Generally, Meritain Health uses a birthday rule to decide which of the two plans would be the primary plan.

If you say “no” to this plan now.

- You can refuse the benefits of this plan, but be sure you’ve looked at the pluses and minuses of that decision. Important: If you don’t enroll now, you’ll have to wait for your employer to offer an open enrollment period.
- If you lose other group benefits that you or your dependents might have, and it’s not your fault (for example, the covered person is laid off or let go from a job) you’ll be able to sign up for this plan. Likewise, if you have an event such as your own marriage, divorce, or the birth or adoption of a child, you will have another brief period to sign up for this plan without waiting for your employer’s open enrollment period, which runs from August 15th through September 30th, for an effective date of September 1st. These are considered “Qualifying Events.”

Pre-existing condition limitation.

If you’ve had treatment for a health condition, or if treatment for a condition has been recommended but not received, within the six months before your enrollment in this plan, that condition may be considered “pre-existing” and won’t be covered by this plan for up to 12 months. If you enroll late, the condition may not be covered for 18 months.

However, if a person has had other creditable healthcare benefits within 63 days of enrolling for this plan, that coverage time will be subtracted from the pre-existing condition limitation period. Waiting periods do not count as creditable coverage.

To reduce your pre-existing condition limitation period under this plan, contact your previous employer to get a Certificate of Creditable Coverage showing how long you were covered under that employer’s health plan. Keep a copy for yourself and give one to your employer. If you have questions, or any problems getting the Certificate, talk to your employer.

Please note: Pregnancy is never considered a pre-existing condition.

Creditable coverage.

If you have had other health plan benefits recently, it may be applied to shorten the pre-existing condition limitation of the plan. A pre-existing condition is a health condition for which you received treatment within a stated period of time as defined by your plan.

Here’s how it works:

If within the 63 days before this plan becomes effective, you or any eligible dependent was covered by another healthcare plan (creditable coverage), the time enrolled in the previous plan is subtracted from the length of pre-existing condition limitation, shortening it or eliminating it altogether.

A creditable health plan means:

- Another employer-sponsored group plan
- COBRA continuation coverage
- An HMO
- Individual healthcare insurance
- Medicaid and/or Medicare
- A public health plan
- Peace Corp plan
- State Childrens Health Insurance program

Plans that aren’t considered creditable are:

- Long-term care benefits
- Disability income insurance
- Auto medical payment insurance

Open enrollment period.

If you waive or decline benefits at first but change your mind later, you can sign up during the time period designated by your employer. Open enrollment is August 15th through September 30th with an effective date of September 1st.

Special enrollment situations.

In these situations, you may be able to add, delete or change your benefit choices.

- Involuntary loss of other benefits
- Marriage
- Birth
- Adoption
- Placement of a child in your home for adoption

Special enrollment time limit.

If you’re adding a dependent to your benefits through a special enrollment situation (marriage, birth, adoption, loss of the dependent’s other benefits, etc.), let your employer know within 31 days of the marriage, birth, adoption, etc.; however, this can vary by group.

The birthday rule.

If both parents provide benefits for a child, then the primary plan is the one from the parent whose birthday comes first in the year.

So, if one parent’s birthday is January 12 and the other parent’s is April 1, the primary payer will be the plan from the parent whose birthday comes first—January 12. In the unusual case that both parents have the same birthday, the plan of the parent who has provided benefits longest for the child will be primary.

Balancing Your Life Means Protecting Your Health

Understanding your Medical Benefits.

Chances are, you try every day to restore a healthy balance to your life, but time gets away from you, or other details come first. Meritain Health is here to help you focus, to support you every step of the way. Read about your benefits in the next sections, and learn all you can about using your plan to make healthy changes. Think of the benefits and programs as an important resource in the protection of your body, mind and spirit!

Preventive care for you and your family: Protecting your healthy balance.

Question: Which is better: Taking an hour or two out of your busy day to have your annual checkup—or missing hidden symptoms and paying the price in sick days, copays and missed events?

Answer: Nothing makes more sense in these busy times than preventing illness before it happens. That's why your plan offers excellent benefits for preventive services.



Preventive Care-exams:

Combined in-network and out-of-network

Well baby exam	80% (no deductible)
Physical Examination related to school, sports and employment	80% (no deductible)
Routine Physical Exams including associated x-rays, labs and test	80% (no deductible)
Routine immunizations/vaccinations	80% (no deductible)
Routine Hearing Exam	100% (no deductible); 1 per calendar year
Cancer screenings	
Routine pelvic exam and associated lab work (age 18 and over)	80% (no deductible); 1 per calendar year
Routine prostate exam and associated labwork (age 40-49 for high risk or 50 and over)	80% (no deductible); 1 per calendar year
Routine mammogram	
One baseline mammogram for females (35 years - 39 inclusive)	80% (no deductible)
One mammogram every other year for females (40-49)	80% (no deductible)
One annual mammogram for a female (50 and over)	80% (no deductible)
One mammogram at any age for a female with a history of breast cancer or whose parent or sibling has a history of breast cancer if recommended by a physician	80% (no deductible)

In this section:

- Preventive care
- Online tools at myMERITAIN.com
- Using your benefits
- Medical Management and precertification
- Dental care
- Vision care
- Prescription benefits
- Life benefits

Customer support.

Contact us to talk to a representative, dedicated to helping you get the most from your plan: **1.866.808.2609**

About your Deductible.

The deductible does not apply to everything your plan covers. Be sure to spend some time reviewing the Summary of Benefits in the Appendix of this packet for more details.

Healthcare for you and your family:

When sickness or injury throw you off balance.

Knowing that you're in good hands when you're sick is one of the most comforting feelings there is. You can be assured that your health plan has everything you'll need to get the right care when something goes wrong.

Remember this: Meritain Health is only a phone call away. If you have questions about your provider network, benefits, deductibles or claims, just give us a call.

Balancing healthcare costs: What you pay and what the plan pays.

The Summary of Benefits in the Appendix of this packet shows how much you pay for care, and how much the plan pays. It's a listing of what is and isn't included in your benefits plan. For more detailed information, see your summary plan description.

After you pay your annual deductible and any up-front copays, the plan begins to pay a percentage of your provider's charges, for example 80%. The remaining percentage, for example 20%, is your responsibility—your "out-of-pocket" costs. You're protected from financial hardship by a maximum out-of-pocket amount each year—the most you'll have to pay before the plan covers costs at 100%. (Copays do not apply to the out-of-pocket maximum.)

Medical benefits at-a-glance:

	Combined in-network and out-of-network
Physician's office visits	80% after deductible
Deductible	
Per individual	\$50
Per family	\$150
Coinsurance percent	20%
Out-of-pocket maximum* (excluding deductible)	\$800/individual

**Non-PPO Hospital out-of-pocket expenses do not accrue toward the Calendar Year out-of-pocket maximum expense.*

24-hour access to tools you can really use at www.myMERITAIN.com.

The Meritain Health member Web site, www.myMERITAIN.com, is designed to provide a secure, user and family-friendly, one-stop-shop for you to access the account and claims information you can use to manage your health and wellness.

We're committed to providing you with all the basics you expect, along with added features to support a healthy lifestyle, assist you with medical decisions, and give insight into the maximization of your healthcare dollars.

Go to myMERITAIN.com to log in to our secure site.

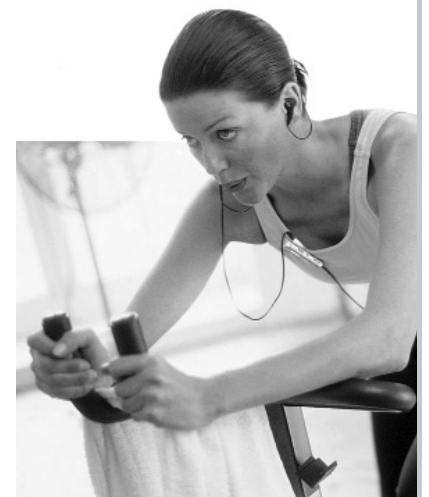
Return users, just sign in using your username and password. The first time you access the site, you will be prompted to re-register with a new username and password for enhanced security. Then take advantage of the smart, safe resources your health plan offers, right at your fingertips.

Helpful tip:

It's important to know what is covered under your health plan. This can help you to plan for the cost of your healthcare expenditures. For more information, refer to your summary plan description.

At myMERITAIN.com you can:

- Look up health and wellness topics in our online medical library.
- Find the status of a claim.
- Find network doctors, clinics and hospitals.
- Look up prescription and over-the-counter drug information.
- Order ID Cards.



New users can create an account by following the easy instructions. You'll need your health plan ID Card the first time. Remember, each member of your family can have an account, too.

Privacy Regulations.

Members over 18 years of age have partially protected information according to HIPAA Privacy Regulations. *Members over 18 having difficulty creating an account with their SSN, please contact Meritain Health Customer Service at: 1.866.808.2609.*

Using your medical benefits.

Save when you see network providers.

This plan offers a Preferred Provider Organization (PPO), a network of doctors and other healthcare professionals who have agreed to accept lower amounts than their standard charges, just for members of this plan. These lower amounts are negotiated and predetermined. That means when you see a PPO provider, your share of costs is based on a lower charge—so your costs are lower, too. PPO providers are conveniently located in both urban and rural areas. Lower costs and convenient doctors and clinics are important ways that Meritain Health can support your efforts to stay well and have a healthy lifestyle—or to get care as simply as possible when you're sick.

Remember: If you go outside the network, you may still have benefits, but your share of costs will be higher, and the amount you pay will not be based on a lower rate.

No referrals needed—how convenient!

You don't have to choose a primary care doctor to direct all of your care or to provide referrals to specialists, but Meritain Health recommends that you build a relationship with a "home base" doctor—one who has all of your records and health history. For best benefits, see specialists in the PPO network (called "in-network" or "participating" providers). Remember, if you see providers outside the network, you'll share more of the cost. To be sure the plan pays for charges from any out-of-network provider you choose, call customer service before you receive care.

When it's an emergency.

If you can't see a network provider in an emergency, don't worry! Your plan will cover out-of-network emergency charges at the in-network level. For more information, refer to your summary plan description.

When an out-of-network provider's charges may be covered at the in-network rate.

If an out-of-network provider is under agreement with an in-network provider for some part of your care (for example, an out-of-network anesthesiologist or pathologist who regularly works with your doctor) the out-of-network provider's charges will be paid at the in-network rate. All plan limitations, requirements and provisions apply.

Important: If you (or your in-network provider) could choose an in-network provider for services or consultation, but decide instead to use an out-of-network provider, benefits are reduced to the out-of-network level.

Helpful Tip:

By visiting doctors and facilities within your PPO network, who have agreed to accept discounted rates for seeing Meritain Health members, you can realize savings while on the road to meeting your annual deductible.

Re-claiming your time.

With some health plans, paperwork can put you over the edge. Time-consuming and complicated, claim forms rob you of precious time and the balance you seek. That's why Meritain Health PPO providers file your claims for you. Pay your copay (if applicable), and you're on your way!

If you see an out-of-network provider, you pay the full cost of services when you receive care, then submit a claim to the address shown on the back of your ID Card.

Support for your health journey.

Your employer wants you to get the best, most appropriate care, when and where you need it. That's why your plan includes the extra expertise of Hines and Associates' Medical Management program. The Medical Management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering. Registered nurses review treatment plans, then help to assure that you get the right treatment in the right setting, when you need it.

Before you get care, call Medical Management.

To keep your benefits at the highest level, be sure to call Medical Management before any of these situations:

- Admission to the hospital for elective or non-emergency care and before additional hospital days.
- Within 48 hours (two working days) after an emergency or urgent hospital admission.
- Before maternity hospitalization
- Before inpatient substance-abuse treatment or treatment for a mental health disorder.

Improve your overall health with dental benefits.

It's amazing how important your oral health can be to your body's total balance and wholeness. Did you know that good dental care not only helps to prevent periodontal disease, but can also add as many as 6 years onto your life? That's just one of the reasons why this plan includes dental care benefits for you and your enrolled dependents. Regular check-ups can keep your smiles bright and beautiful.

Dental plan deductibles and plan maximum:

Deductible

Per individual	\$50
Per family	\$150

Annual maximum \$3,000 combined calendar year maximum

Hines and Associates Medical Management.

Contact a Medical
Management Nurse at:
1.888.437.9927

Medical Management nurses focus on:

- The recommended treatment for your health condition.
- The proposed location of your treatment.
- The proposed length of stay at that location.
- The cost-effectiveness of your treatment and setting.

You and your doctor always have the right to appeal a decision made by the Medical Management team if you disagree with their decision. A panel of doctors will review the appeal.

Covered Dental Services:

Preventive & diagnostic

Subject to deductible?	NO
Plan payment	100%

Basic restorative

Subject to deductible?	YES
Plan payment	90%

Major restorative

Subject to deductible?	YES
Plan payment	50%

Vision care: Part of any balanced healthcare picture.

To lead your busy life, you need to protect your vision, so your benefit plan includes eye care. Visit any vision care provider and pay for your care at the time you receive it. Then download a claim form at www.myMERITAIN.com and send the completed claim to Meritain Health at the address shown on your ID Card. You'll be reimbursed for the covered services shown below:

Vision benefits:

Routine eye exams	80%
Eyeglasses or contact lenses	80%
Eyeglass frames	\$80

Limitations:

- One complete eye exam per person, per calendar year
 - One set of eyeglass lenses or a 12-month supply of contact lenses per person, per calendar year
 - One set of frames per person every 2 consecutive calendar years
-

A prescription for a healthier budget.

When you need prescriptions filled, you have your easy-to-use prescription drug benefit. But to get the most from your benefits plan, it pays to be a wise consumer.

Your prescription drug benefit is administered by Scrip World, together with Express Scripts. They provide unbeatable resources for our plan participants. The Express Scripts pharmacy network includes more than 96 percent of all independent and chain pharmacies nationwide.



Controlling your prescription copay.

In many cases, you can control how much your share of costs will be when you fill a prescription. How? Generic drugs cost less to manufacture, and they're just as effective as the name brands. You'll save money when you request them because generics have a lower copay than preferred or non-preferred drugs.

Prescription drug copays:

Combined in-network and out-of-network

Retail network pharmacy (90-day supply)	80% after deductible
Mail order (90-day supply)	80% after deductible

Why generics make sense—and dollars.

Because companies that develop new drugs have long-term patent protection for their products, other drug companies are prevented by law from manufacturing those drugs—even if they can produce them less expensively.

When patents expire, other companies can make equivalent drugs, usually at a much lower price. Generic equivalents go through rigorous FDA testing regularly to assure that they are just as effective as the brand-name drugs.

Consider all of the compelling reasons to protect your pocketbook with the lower-price generic drugs:

- Generics can cost up to 75 percent less than their brand-name equivalents.
- FDA testing is exactly the same for generic and brand-name drugs.
- Generics contain the same active ingredients as the original, brand-name drug, in the same amounts and dosages.
- Generic drugs sometimes look different from the original brand-name drug in color or shape, but only because they may have different inactive ingredients that won't change how the drug works.
- Nearly half of all brand-name drugs have generic equivalents—but you may have to ask for them.

Easy on your time: Three ways to get your prescription drugs.

Your plan is designed with your time in mind. Use any of these three prescription options.

Retail Pharmacy Option.

When you need a prescription for 30 days or less, have it filled at a participating pharmacy. Just show the pharmacist your Meritain Health ID Card and pay your copay at the time of your purchase. If the pharmacy you choose is not in the network, you'll pay the entire cost at the time of purchase, then submit a claim for reimbursement. You'll receive the same amount that a participating pharmacy would receive, minus your copay.

Contact Scrip World.

SCRIP WORLD



1.877.468.6592

Helpful tip:

Be sure to bring your Meritain Health ID Card with you to the pharmacy when filling prescriptions. This will ensure that you receive your full benefits.

Not every drug is covered.

The plan does not include benefits for over-the-counter medications or drugs used for cosmetic purposes. There may be other exclusions. Scrip World customer service can help you if you have questions, or refer to your more complete summary plan description.

Mail Order Option.

If you have a chronic condition and you take medication for it for long periods of time, you may fill prescriptions by mail. Ask your doctor to write two prescriptions—one for 30 days, and one for 90 days. Fill the 30-day prescription at a network pharmacy. Then complete a mail order form and send it, along with the original 90-day prescription signed by your doctor and your copay, to the address on the form.

Online Option.

You can also fill 90-day prescriptions online at www.myMERITAIN.com. Again, ask your doctor for two prescriptions. Before you request your prescription online, fill the 30-day order at a network drug store, and send (or ask your doctor to send) the 90-day prescription to the address shown on the Web site. Simply use a credit card to pay your copay.

Certain drugs must be approved.

If your prescription is for a very expensive drug, or one that can be easily abused, prior authorization may be required. Trained professionals review these prescriptions for your protection. You may need a new written prescription from your doctor for each refill. For more information, see your summary plan description or contact Scrip World customer service at 1.877.468.6592.

Financial security adds to peace of mind.

Responsible, hardworking people have a lot on their minds. That's why your employer has included benefits that can protect your family if you're not able to provide your regular financial support. They're good for your peace of mind—and peace of mind is good for your health and well-being.

Life and AD&D insurance.

These important coverages protect your beneficiaries against the financial hardship that the loss of your income might cause.

Prescriptions and www.myMERITAIN.com.

- Order new prescriptions.
- Check the status of your online order.
- Find a nearby network pharmacy.
- Check on the price of a drug.
- Research drugs, supplements and vitamins.
- Learn more about your coverage.

Find Balance Between a Good Life and Good Health

Join us!

Are you ready to commit to a health plan that can help restore balance to your life? It's simple to enroll—just follow these four steps. And if you have any questions during the enrollment process, check with your benefits administrator. Once you've completed Step 4 and you've served any waiting period, you're on your way to a fresh new approach to living your best health.

Step 1: Gather your information.

For a complete, efficient enrollment, you may need some of the information below.

- Spouse's and children's birth dates.
- Spouse's and children's Social Security Numbers (SSN).
- Date of marriage.
- If your spouse or children are covered under another health plan, the name of the plan or insurance carrier and the effective date of benefits.
- If your benefits will include life insurance, your beneficiaries' names and SSNs.

Step 2: Double-check every form.

The decisions you make as you enroll in your health plan will affect your future healthcare and finances. We want to help you choose wisely. If you have not yet read the earlier sections of this packet, take time to do it now. Don't enroll without understanding your options.

Consider:

- Your personal health and the health of your family members.
- Healthcare expenses you can predict for you and your family.
- Other health benefits you or your family members may have.
- Your budget for benefits and expected healthcare services.

Remember:

Copays and deductibles are out-of-pocket costs you will pay for doctor visits and other medical services.

If you or any dependent(s) are covered by another health plan, you have several options.

If you decline benefits now, you won't be able to enroll later unless a special enrollment situation occurs, or during an open enrollment period.

Step 3: Make your decision.

It's time to make changes in the way you think about your health and your healthcare. It's time to step up, take charge and make the best use of your plan, your money and your time. Are you ready to commit to better health, a better life—and the balance you want? Meritain Health is ready and committed to helping you.



In this section:

- Gathering information
- Double checking your information
- Making your decision
- Completing enrollment
- A more balanced you

No waiting period.

Your plan does not have a waiting period. Your benefits begin on your date of hire.

Step 4: Complete your enrollment, and you're on your way!

All eligible employees must complete the enrollment form (see Appendix), whether you're choosing this plan or declining benefits.

Complete, sign and return your enrollment form to your employer within 31 days of your eligibility date whether you're enrolling or declining benefits.

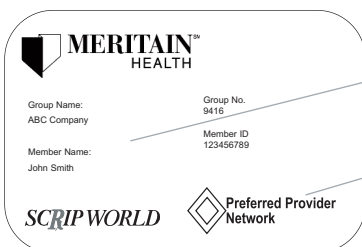
- If you're enrolling a dependent who is beyond the age limit for benefits, you must tell us whether that dependent is a full-time student or disabled, and provide supporting documentation.
- Write clearly! If your form is unreadable, your enrollment may be delayed.
- Don't forget the back side of the enrollment form! Missing or incomplete information will delay your enrollment.
- Remember to sign and date the form, even if you're declining benefits.
- If you need to prove you've had prior healthcare benefits to satisfy the pre-existing limitation period, be sure to request a Certificate of Creditable Coverage from your previous health plan. Give one copy to your benefits administrator and keep a copy for your files.

The final step toward better balance and better living.

After you've completed enrollment, your employer has approved it, and after any waiting period has passed, your benefits will be effective.

Your Meritain Health ID Card will be on its way to you soon. The card shows Meritain Health as your health plan administrator. Keep it in your wallet and carry it with you.

Sample ID Card:



- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents' benefits.
- You are enrolled in a Preferred Provider Organization (PPO) healthcare plan. To receive the in-network level of benefits, your provider must participate in the PPO. Call the provider info number for participating providers.



- Please ensure that you precertify with Meritain Health Medical Management, if required.
- All claims should be submitted to Meritain Health at this address.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- You can call for information on a doctor or specialist who is close to you and serves your specific needs.

Until you receive your ID Card.

Not to worry—If you need to see your doctor but you don't have your ID Card yet, just tell the clinic staff that you're a member of this plan. The clinic will contact Meritain Health customer service to verify your benefits.

If you need a prescription before you get your new Meritain Health ID Card, tell the pharmacist that you have new health plan information:

- Give Express Scripts as the name of your pharmacy benefit manager
- Give your pharmacist the Express Scripts Rx Group #: "B65E"
- Provide the ID number and birth date of the person named on the prescription

If you're unable to have your prescription filled this way, just pay for your prescription and send us a completed prescription drug claim form (see the Appendix for a copy). Send your receipt and the completed claim form to the address shown on the form and you'll be reimbursed up to plan limits, minus any copay.

You or your pharmacist may contact Scrip World customer service at **1.877.468.6592** with any questions.

Lost ID Card?

Contact Meritain Health at: **1.866.808.2609**

Appendix

- **Glossary**
- **Summary of Benefits**
- **Important phone numbers**
- **Enrollment forms**
- **Claim forms**

Glossary of terms.

Ambulatory Surgery. Surgery performed at an ambulatory surgical facility (a licensed public or private facility), which does not provide services or accommodations for a patient to stay overnight.

Certificate of Creditable Coverage. A certificate issued by an employee's former health plan that verifies the length of creditable coverage for purposes of shortening or eliminating a pre-existing limitation period. See "creditable coverage."

Creditable coverage. Previous health plan benefits that may be applied to shorten or eliminate a plan participant's pre-existing limitation period for a pre-existing condition. Most types of health insurance, including group health plans, COBRA coverage, HMO, individual health insurance policies, Medicaid and Medicare, are considered creditable coverage.

Copay. An amount of money that a participant is required to pay each time he or she visits a healthcare provider or fills a prescription.

Deductible. The annual out-of-pocket amount that a plan participant is responsible for paying before the health plan covers his or her medical costs according to the terms of the plan. Until a person meets the annual deductible, he or she pays the full cost of healthcare services received, unless the service is not subject to the annual deductible as stated in the benefit schedule.

myMERITAIN.com. Your online health information portal and your personal connection to your plan. Here you can order prescriptions, find healthcare providers, research health topics and get answers to your questions about healthcare. The personal information used to access www.myMERITAIN.com is confidential. You may need the information on your ID Card to log in for the first time.

Preferred Provider Organization (PPO). Organization that negotiates special, lower rates for healthcare services provided by physicians and other care providers who are within the PPO's network. Providers who belong to a PPO are called participating or in-network providers.

Usual and customary charge. Your plan reimburses charges from non-participating or out-of-network providers that are equal to, or less than, usual and customary charges. Usual and customary charges are the amounts most frequently charged for the same service:

- In the same geographic area; and
- By other providers in the same or similar medical area.

The fees charged by non-participating providers may exceed the usual and customary charges recognized by your plan. In such cases, Meritain Health will process an amount equal to the usual and customary charge for the healthcare service you received, and you will be reimbursed for a portion of that amount according to your plan's out-of-network benefits.

Summary of Benefits

	PPO and Non-PPO (Combined)
MAJOR MEDICAL Deductible Coinsurance Percent Out-of-Pocket Maximum (Excluding Deductible) *Non-PPO Hospital out-of-pocket expenses do not accrue toward the Calendar Year out-of-pocket maximum expense* Lifetime Maximum per Family Member	\$50/Individual \$150/Family 20% \$800/Individual \$5,000,000
PREVENTIVE CARE- Exams Well Baby Exam Physical Examination related to school, sports and employment Routine Physical Exams including associated x-rays, labs and test Routine Immunizations/vaccinations Routine Hearing Exam Cancer Screenings: Routine pelvic exam & associated lab work (Age 18 and over) Routine prostate exam & associated lab work (Age 40-49 for high risk or 50 and over) Routine mammogram One Baseline mammogram for females 35yrs~39 inclusive One mammogram every other year for females 40~49 One annual mammogram for female 50 and over One mammogram at any age for a female with a history of breast cancer or whose parent or sibling has a history of breast cancer if recommended by a physician	80% (no Deductible) 80% (no Deductible) 80% (no Deductible) 80% (no Deductible) 100% (no Deductible) 1 per Calendar Year 80% (no Deductible); 1 per Calendar Year 80% (no Deductible); 1 per Calendar Year 80% (no Deductible) 80% (no Deductible) 80% (no Deductible) 80% (no Deductible)
HOSPITAL CHARGES PPO Facility Non-PPO Facility Emergency room care (subject to \$100 emergency room deductible) Non-PPO Hospital out-of-pocket expenses do not accrue toward the Calendar Year Out-of-Pocket Maximum Expense* Pre-Certification Penalty Pre-Certification Penalty- Reduction of benefits per each occurrence when Hospital Admission is not pre-certified.	80% after deductible Constant 60% after deductible 80% after deductible \$250
TRANSPLANTS - ORGAN & TISSUE (Requires Precertification) PPO Facility Non-PPO Facility	80% after deductible Constant 60% after deductible
PHYSICIAN SERVICES Physician's Office Visits Chiropractic Services Outpatient Speech and Hearing Therapy Hospice Care Skilled Nursing TMJ Treatment Office Visits Inpatient Hospital Care and Outpatient Surgery PPO Facility Non- PPO Facility All other Physician Services	80% after deductible 80% after deductible 80% after deductible \$2000 Lifetime Maximum 80% after deductible, 180 days Lifetime Maximum 100% no deductible, 90 day Calendar Year Maximum 80% after deductible 80% after deductible Constant 60% after deductible 80%, after Deductible
MENTAL HEALTH/SUBSTANCE ABUSE	PAID AS ANY OTHER ILLNESS
*Benefits with a constant Benefit Percentage do not accrue towards the Out-of-Pocket Maximum Expense limit.	

Summary of Benefits

	PPO and Non-PPO (Combined)
PRESCRIPTION DRUG EXPENSES	
Retail Network Pharmacy (90-day supply)	80% after deductible
Mail Order (90-day supply)	80% after deductible
DENTAL	
Preventive & Diagnostic	100% (No Deductible)
Basic Restorative Services	90% (After Deductible)
Major Restorative Services	50% (After Deductible)
Deductible	\$50 Individual \$150 Family
Calendar Year Maximum (Preventative, Basic, Major)	\$3,000 - combined Calendar Year Maximum
VISION	
Routine Eye Exams	80%
Eyeglass or Contact Lenses	80%
Eyeglass Frames	\$80
Limitations	
One complete eye exam per person per Calendar Year	
One set of eyeglass lenses or a 12-month supply of contact lenses per person per Calendar year	
One set of frames per person per every two consecutive Calendar Years	
*Benefits with a constant Benefit Percentage do not accrue towards the Out-of-Pocket Maximum Expense limit.	

Important Phone Numbers

For questions about...	You may call...	At this number:
■ Medical/Dental/Vision benefits	Meritain Health Customer Service	1.866.808.2609
■ Prescription drug benefits	Scrip World	1.877.468.6592
■ Participating providers	Multiplan	1.800.557.6794
■ Precertification	Hines and Associates Medical Management	1.888.437.9927
■ Enrollment or benefit questions	Ketchikan Gateway Borough and	1.866.808.2609
■ COBRA benefits	School District	
■ Life and AD&D	Human Resources Representative	

COMPANY NAME: Ketchikan Gateway Borough and School District **GROUP #:** AK160

BENEFIT ENROLLMENT FORM



THIS FORM TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES

PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM
(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED					
LAST NAME		FIRST NAME			MI
SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
MAILING ADDRESS					
CITY			STATE	ZIP	
HOME PHONE NUMBER			WORK PHONE NUMBER		
ARE YOU THE EMPLOYEE COVERED UNDER ANY OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO (i.e. Medicare, Tricare, spouse's plan) IF YES, NAME OF INSURANCE: _____ EFFECTIVE DATE: _____ TYPE OF POLICY (Retiree, COBRA, Spouse): _____ POLICY HOLDER (Self, Spouse): _____ IF ENROLLED IN MEDICARE: EFFECTIVE DATE: PART A _____ PART B _____ HICN _____ ENTITLEMENT TO MEDICARE DUE TO: <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE (ESRD)					

EMPLOYER USE ONLY

DATE OF HIRE	EFFECTIVE DATE
DIVISION #	DEPT. # / CLOCK #
ANNUAL SALARY: \$	
<input type="checkbox"/> HOURLY <input type="checkbox"/> SALARY	
<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> COBRA	
<input type="checkbox"/> ENROLLMENT CHANGE <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Reinstatement <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Other: _____	
Employer Representative Signature: _____	
Date: _____	

BENEFIT SELECTION			
COVERAGE TYPE	PLAN ELECTED (IF APPLICABLE)	PPO (IF APPLICABLE)	COVERAGE LEVEL
<input type="checkbox"/> LIFE/AD&D			<input type="checkbox"/> SINGLE
<input type="checkbox"/> MEDICAL			<input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYEE + SPOUSE <input type="checkbox"/> EMPLOYEE + CHILD <input type="checkbox"/> EMPLOYEE + CHILDREN <input type="checkbox"/> FAMILY <input type="checkbox"/> DECLINE
<input type="checkbox"/> PRESCRIPTION			<input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYEE + SPOUSE <input type="checkbox"/> EMPLOYEE + CHILD <input type="checkbox"/> EMPLOYEE + CHILDREN <input type="checkbox"/> FAMILY <input type="checkbox"/> DECLINE
<input type="checkbox"/> DENTAL			<input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYEE + SPOUSE <input type="checkbox"/> EMPLOYEE + CHILD <input type="checkbox"/> EMPLOYEE + CHILDREN <input type="checkbox"/> FAMILY <input type="checkbox"/> DECLINE
<input type="checkbox"/> VISION			<input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYEE + SPOUSE <input type="checkbox"/> EMPLOYEE + CHILD <input type="checkbox"/> EMPLOYEE + CHILDREN <input type="checkbox"/> FAMILY <input type="checkbox"/> DECLINE

BENEFICIARY DESIGNATION					
PRIMARY BENEFICIARY	NAME: _____		SECONDARY BENEFICIARY	NAME: _____	
	RELATIONSHIP: _____			RELATIONSHIP: _____	
	SS#: _____	PERCENTAGE: _____		SS#: _____	PERCENTAGE: _____

DEPENDENT INFORMATION (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)							
<i>Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP).</i> If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances: a. The employee or eligible dependent loses their eligibly status to participant in Medicaid or CHIP; or b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides. The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.							
DEPENDENT FULL NAME (REQUIRED) (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NO. (REQUIRED)	RELATIONSHIP * (REQUIRED)	DATE OF BIRTH (MM/DD/YY)	GENDER (M/F)	CHECK COVERAGE		DISABLED DEPENDENT**
					<input type="checkbox"/> MEDICAL <input type="checkbox"/> RX	<input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> MEDICAL <input type="checkbox"/> RX	<input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> MEDICAL <input type="checkbox"/> RX	<input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> MEDICAL <input type="checkbox"/> RX	<input type="checkbox"/> DENTAL <input type="checkbox"/> VISION	<input type="checkbox"/> YES <input type="checkbox"/> NO
*IF ENROLLING STEPCHILDREN, DO THEY RESIDE WITH EMPLOYEE? <input type="checkbox"/> YES <input type="checkbox"/> NO **IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION							

FULL TIME STUDENT INFORMATION (DEPENDENTS OVER AGE 19)					
DEPENDENT NAME	NAME OF COLLEGE	COLLEGE PHONE NUMBER	SEMESTER	NUMBER OF CREDIT HOURS	DO YOU PROVIDE THE MAJORITY OF SUPPORT FOR DEPENDENT?
					<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO
Starting the first day of the first plan year after October 9, 2009, for any covered dependent child who is enrolled in a post-secondary educational institution as condition of enrollment in the plan, who needs to take a medically necessary leave of absence (or reduce their student hours) due to their own serious illness or injury, coverage will be extended for that dependent child upon written certification by their treating physician that states the dependent is suffering from a serious illness or injury and that a leave of absence (or reduction in student hours) is medically necessary. If written certification is not received from the treating physician containing the above information, the plan will not provide the continued coverage. Coverage will be continued under the health plan until the earlier of (1) one year after the first day of the medically necessary leave of absence; (2) the date the dependent is no longer suffering from a serious illness or injury or (3) the date on which the coverage under the plan would otherwise terminate. In order for this extension to be fully granted, please refer to your Plan Document for more details regarding the extension.					

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Health Claim Form



Complete and send to:
 Meritain Health
 P.O. Box 27267
 Minneapolis, MN 55427-0267
Fax: 1.952.582.2839

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

EMPLOYEE INFORMATION					
Name (last, first, initial)		Sex	Employer Name		
Home Address		Identification Number	Birthdate	Group Number	
City	State	ZIP Code	Work Telephone ()	Home Telephone ()	
PATIENT INFORMATION					
The Patient is: <input type="checkbox"/> THE EMPLOYEE (go to No. 3) <input type="checkbox"/> EMPLOYEE'S SPOUSE (complete spouse information) <input type="checkbox"/> EMPLOYEE'S CHILD (complete spouse and child information)					
Spouse's Name (last, first, initial)		Sex	Child's Name (last, first, initial)		Sex
Spouse's Birthdate	Spouse's Social Security Number		Child's Birthdate	Child's Social Security Number	
Spouse's Employer			If child is over age 19 and full-time student, complete: Name of School:		
Spouse's Employer's Address			School Address		
OTHER COVERAGE					
<input type="checkbox"/> YES (then complete)		<input type="checkbox"/> NO (go to No. 4)		NAME OF POLICYHOLDER:	
Name of Other Health Insurance Carrier or Plan		Address		City	State ZIP Code
Other Insurance Carrier's or Plan's Telephone No.		Type of Coverage <input type="checkbox"/> GROUP <input type="checkbox"/> INDIVIDUAL		Group Number	Contract or Policy Number
Spouse's Employer			If child is over age 19 and full-time student, complete: Name of School:		
Spouse's Employer's Address			School Address		
ABOUT THIS CLAIM					
<input type="checkbox"/> INJURY <input type="checkbox"/> ILLNESS		Describe injury, when and how it happened or nature of illness:			
Date and time of accident:					
Was injury the result of auto accident? <input type="checkbox"/> YES <input type="checkbox"/> NO		If auto insurance involved, please provide: Policy No Name of Insurance Company Address (City, State, ZIP Code)			
Work related injury? <input type="checkbox"/> YES <input type="checkbox"/> NO		If injury is work related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.			
<input type="checkbox"/> WELL CHILD CARE <input type="checkbox"/> ROUTINE PHYSICAL EXAM		If illness, date of first treatment: If pregnancy, expected delivery date:			
EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED					
The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.					
Signature _____			Date _____		
ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)					
I authorize payment of benefits directly to the doctor or supplier of services listed here.					
Provider to be paid _____			Employee's Signature _____		
Provider's Tax ID No. or Social Security No. _____			Date _____		



IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill.

PHYSICIAN OR SUPPLIER STATEMENT																				
A	Patient Name (last, first, middle initial)				Birthdate															
B	Address																			
C	Is condition the result of an injury arising from patient's employment? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please contact the Workers' Compensation Carrier/Administrator for proper instruction regarding this claim.</i>																			
D	Pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO				If yes, expected date of delivery															
E	If illness, date of first treatment				If treating injury, date of injury															
F	Name of referring physician				Referring physician's address															
G	Name and facility where services were rendered (if other than home or office)																			
H	Was laboratory work performed outside your office? <input type="checkbox"/> YES <input type="checkbox"/> NO																			
I	For service related to hospitalization, give dates: <input type="checkbox"/> ADMITTED _____ <input type="checkbox"/> DISCHARGED _____																			
J	Diagnosis and current conditions (if diagnosis other than ICD-9* used, give name): 1. 2. 3. 4.																			
K	Dates of Service	Places of Services†	Procedure Code (If other than CPT** code used, give name)	Description of surgical or medical services rendered	Diagnosis Code	Charges														
	From To																			
<table style="width:100%; border: none;"> <tr> <td style="font-size: small;">* ICD-9 International Classification of Disease</td> <td style="font-size: small;">† ABBREVIATIONS:</td> <td style="font-size: small;">11 - Physician's Office</td> <td style="font-size: small;">21 - Inpatient Hospital</td> <td style="font-size: small;">23 - Emergency Room</td> <td colspan="2"></td> </tr> <tr> <td style="font-size: small;">** CPT Current Procedural Terminology (current edition)</td> <td></td> <td style="font-size: small;">12 - Patient's Home</td> <td style="font-size: small;">22 - Outpatient Hospital</td> <td style="font-size: small;">81 - Independent Laboratory</td> <td colspan="2"></td> </tr> </table>							* ICD-9 International Classification of Disease	† ABBREVIATIONS:	11 - Physician's Office	21 - Inpatient Hospital	23 - Emergency Room			** CPT Current Procedural Terminology (current edition)		12 - Patient's Home	22 - Outpatient Hospital	81 - Independent Laboratory		
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** CPT Current Procedural Terminology (current edition)		12 - Patient's Home	22 - Outpatient Hospital	81 - Independent Laboratory																
Date Physician's Name (print) Degree				Provider's Tax ID No. or Social Security No. 																
Physician's Signature _____ Telephone ()				<i>Must be furnished under authority of law</i>																
Street Address			City		State	ZIP Code														

STATUS AND BENEFIT INFORMATION:
1.800.925.2272



Send to:
 Meritain Health
 P.O. Box 27267
 Minneapolis, MN 55427-0267
Fax: 1.952.582.2839

Dental Claim Form



Complete and send to:
 Meritain Health
 P.O. Box 27267
 Minneapolis, MN 55427-0267
Fax: 1.952.582.2839

IMPORTANT: Please have your dentist or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

EMPLOYEE INFORMATION					
Name (last, first, initial)			Sex	Employer Name	
Home Address			Identification Number	Birthdate	Group Number
City	State	ZIP Code	Work Telephone ()	Home Telephone ()	
PATIENT INFORMATION					
The Patient is: <input type="checkbox"/> THE EMPLOYEE (go to No. 3) <input type="checkbox"/> EMPLOYEE'S SPOUSE (complete spouse information) <input type="checkbox"/> EMPLOYEE'S CHILD (complete spouse and child information)					
Spouse's Name (last, first, initial)			Sex	Child's Name (last, first, initial)	
Spouse's Birthdate		Spouse's Social Security Number		Child's Birthdate	
Spouse's Employer		If child is over age 19 and full-time student, complete: Name of School:			
Spouse's Employer's Address		School Address			
OTHER COVERAGE					
<input type="checkbox"/> YES (then complete)		<input type="checkbox"/> NO (go to No. 4)		NAME OF POLICYHOLDER:	
Name of Other Health Insurance Carrier or Plan		Address		City	State ZIP Code
Other Insurance Carrier's or Plan's Telephone No.		Type of Coverage <input type="checkbox"/> GROUP <input type="checkbox"/> INDIVIDUAL		Group Number	Contract or Policy Number
Spouse's Employer		If child is over age 19 and full-time student, complete: Name of School:			
Spouse's Employer's Address		School Address			
ABOUT THIS CLAIM					
<input type="checkbox"/> INJURY <input type="checkbox"/> ILLNESS		Describe injury, when and how it happened or nature of illness:			
Date and time of accident:					
Was injury the result of auto accident? <input type="checkbox"/> YES <input type="checkbox"/> NO		If auto insurance involved, please provide: Policy No Name of Insurance Company Address (City, State, ZIP Code)			
Work related injury? <input type="checkbox"/> YES <input type="checkbox"/> NO		If injury is work related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.			
EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED					
The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.					
Signature _____			Date _____		
ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)					
I authorize payment of benefits directly to the dentist or supplier of services listed here.					
Provider to be paid _____			Employee's Signature _____		
Provider's Tax ID No. or Social Security No. _____		Date _____			



IMPORTANT: Please have your dentist or supplier of medical services complete the reverse of this form or attach a fully itemized bill.

PHYSICIAN OR SUPPLIER STATEMENT

A	Patient Name (last, first, middle initial)		Birthdate	
	Address			
B	Dentist's Name			
	Address			
	City	State	ZIP Code	Telephone ()
	Provider's Tax ID No. or SSN: <input type="text"/>		Dentist's License No.:	

C	Is treatment a result of injury arising from patient's employment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, description and date:
	Is treatment the result of an auto accident?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, description and date:
	Are any services covered by another plan?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, name of other plan:
	If prosthesis, is this an initial placement?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, reason for placement and date of previous placement:
	Is treatment for orthodontics?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date appliances placed: Mo. of treatment remaining:
D	Is this claim for a pre-treatment estimate?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, are x-rays enclosed? <input type="checkbox"/> YES <input type="checkbox"/> NO

EXAMINATION AND TREATMENT RECORD

E		Tooth No. or Letter	Surface	Procedure Number (ADA)	Description of Services (include x-rays, prophylaxis, materials used, etc.)	Date of Service	Charges	

F	I hereby certify that the above procedures have been completed on the date indicated.	
	Dentist's Signature _____	Date _____

STATUS AND BENEFIT INFORMATION:
1.800.925.2272



Send to:
Meritain Health
P.O. Box 27267
Minneapolis, MN 55427-0267
Fax: 1.952.582.2839

Cardholder's Name (last, first, MI)	Date Of Birth	Gender M F	Cardholder ID Number
Check if new address Address Street _____ City/State _____ Zip Code _____ Daytime Telephone (____) _____			
Employer	Insurance Carrier	Group Number	

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor.



Cardholder's Signature _____

Date _____

Patient Information (please list information for each patient submitting claims)

1	Patient's Name	Relationship to Cardholder?(circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	Total number of receipts attached:
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor) and DEA#:		

2	Patient's Name	Relationship to Cardholder?(circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	Total number of receipts attached:
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor) and DEA#:		

3	Patient's Name	Relationship to Cardholder?(circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	Total number of receipts attached:
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor) and DEA#:		

Does the patient reside in an **assisted living facility**? yes no Is this claim for **allergy serum**? yes no
 Does the patient have primary prescription drug coverage through another insurance carrier? yes no
 Did the patient submit this claim to the other carrier? yes no *If yes, please attach an explanation of benefits from your primary carrier.*

Prescription Information

→ IMPORTANT ← All prescription claims must have prescription receipts/labels which include:
 • Pharmacy Name/Address • Date Filled • Drug Name, Strength and NDC • Rx Number • Quantity • Days Supply • Price • Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed

- Please tape receipts to separate piece of paper
- Patient history print outs from the pharmacy are also acceptable but **MUST** be signed by the Pharmacist.
- CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.** (exception--diabetic supplies, see below)



Is claim for **DIABETIC SUPPLY**? yes no. If **Yes**, Please provide receipt stating: Pharmacy Name/Address • Date Filled • Type of Insulin and/or Type of supply • Quantity • Days Supply • Price • Patient's Name. Cash register receipts are acceptable but **Pharmacist Signature** is required if any information is handwritten.

Ask your pharmacist how you can purchase diabetic supplies with your prescription card

REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

ESI USE ONLY

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE FORM ON REVERSE SIDE.

Cardholder's Information (The Cardholder is the insured member whose employer provides this benefit)

1. Print Cardholder's name (last, first, middle initial).
2. Print Cardholder's date of birth.
3. Circle the correct letter to indicate if Cardholder is male or female.
4. Print Cardholder's ID number (found on prescription drug or Health Insurance card).
5. Print Cardholder's mailing address and telephone numbers. Check box if this is a new address.
6. Indicate Cardholder's employer, insurance carrier and group number (refer to drug card).

**IMPORTANT: CLAIM FORM MUST BE SIGNED
UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED**

Patient Information (Complete a section for each family member who is submitting prescriptions)

1. Print Patient's name.
2. Identify relationship to cardholder, gender, date of birth, and number of prescriptions submitted for each patient.
3. Print Pharmacy name and address and the prescribing Doctor and DEA number used by each patient.

Specific Claim Information

1. Answer each question by checking correct box. Use the space provided for special notes if necessary.

Prescription Information Each submission must include:

Prescription receipts/labels or a patient history printout from your pharmacy, **signed** by the dispensing pharmacist, which include all information listed below:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's name

(Please note that Claims received missing any of the following information may be returned or payment may be denied)

It is preferable to have receipts unattached or taped to a separate piece of paper. *Please DO NOT staple or glue.*

Reason for claim submission or special notes

This section can be used for special notes or comments.

Questions? Call Express Scripts Customer Service Department at 1-800-451-6245

Please return this claim to:

**Express Scripts, Inc.
Member Reimbursements
PO Box 66583
St. Louis, MO 63166
ATTN: Claims Department**



www.myMERITAIN.com