




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](http://www.meritain.com) or call (907) 834-4700. 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call Meritain Health, Inc. at (866) 808-2609 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| <b>What is the overall <u>deductible</u>?</b>                             | For participating <u>providers</u> & non-participating <u>providers</u> : \$100 person / \$300 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> .   |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Eye exams, glasses, dental check-ups and certain surgical procedures (Transcarent SurgeryCare) services 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.   |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | Yes. \$25 individual / \$75 family for dental coverage. There are no other specific <u>deductibles</u> .   | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.  |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For participating <u>providers</u> and non-participating <u>providers</u> : \$488 person   | 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.   |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Copays</u> , <u>deductibles</u> , <u>premiums</u> , dental & vision <u>coinsurance</u> , <u>balance billed</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> .  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.aetna.com/docfind/custom/mymeritain">www.aetna.com/docfind/custom/mymeritain</a> (800-343-3140) or <a href="http://www.tappn.com">www.tappn.com</a> (866-808-2609) 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</u> charge 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No.  | You can see the <u>specialist</u> you choose without a <u>referral</u> .  |

 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<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most)                                   |  |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness | 10% <u>coinsurance</u>                             | 10% <u>coinsurance</u>  | Includes telemedicine.   |
|  | <u>Specialist</u> visit                          | 10% <u>coinsurance</u>                             | 10% <u>coinsurance</u>  |  |
|  | <u>Preventive care/ screening/ immunization</u>  | 10% <u>coinsurance</u>                             | 10% <u>coinsurance</u>  | Includes routine mammogram, pap smear & associated charges, prostate cancer <u>screening</u> , immunizations and routine colonoscopy (ages 45 and over). You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)       | 10% <u>coinsurance</u>                             | 10% <u>coinsurance</u> (free standing facilities)/<br>25% <u>coinsurance</u> (hospital) | -----none-----   |
|  | Imaging (CT/PET scans, MRIs)                     | 10% <u>coinsurance</u>                             | 10% <u>coinsurance</u> (free standing facilities)/<br>25% <u>coinsurance</u> (hospital) |  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a> | Generic drugs                                    | \$5 <u>copay</u> (retail & mail order)             | \$5 <u>copay</u> (retail)   | <u>Deductible</u> does not apply. Covers up to a 90-day supply or 100 unit dose (retail & mail order prescription). The <u>copay</u> applies per prescription. If you use a non-participating pharmacy, you must pay for your prescription at the pharmacy and file your <u>claim</u> for reimbursement through CVS Caremark.                      |
|  | Brand name drugs                                 | \$10 <u>copay</u> (retail & mail order)            | \$10 <u>copay</u> (retail)  |  |
|  | <u>Specialty drugs</u>                           | Paid the same as generic & brand name drugs        |   |  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | 10% <u>coinsurance</u>                             | 10% <u>coinsurance</u> (ambulatory)/<br>25% <u>coinsurance</u> (hospital)               | <u>Preauthorization</u> required unless performed in an office setting. There is no charge and no <u>deductible</u> for certain surgical procedures when they are received through the Transcarent SurgeryCare option.   |
|  | Physician/surgeon fees                           | 10% <u>coinsurance</u>                             | 10% <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>                | 10% <u>coinsurance</u>                          | 10% <u>coinsurance</u> (emergency services)/ 25% <u>coinsurance</u> (non-emergency services)        | <u>Preauthorization</u> required if you are admitted to the hospital. Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> .   |
|   | <u>Emergency medical transportation</u>   | 10% <u>coinsurance</u>                          | 10% <u>coinsurance</u>  | Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for air ambulance.  |
|   | <u>Urgent care</u>                        | 10% <u>coinsurance</u>                          | 10% <u>coinsurance</u>  | -----none-----   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 10% <u>coinsurance</u>                          | 25% <u>coinsurance</u>  | There is no charge and no <u>deductible</u> for certain surgical procedures when they are received through the Translucent SurgeryCare option.   |
|   | Physician/surgeon fees                    | 10% <u>coinsurance</u>                          | 10% <u>coinsurance</u>  |  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 10% <u>coinsurance</u>                          | 25% <u>coinsurance</u> (facility fees)/ 10% <u>coinsurance</u> (professional fees & ancillary fees) | Includes telemedicine.   |
|   | Inpatient services                        | 10% <u>coinsurance</u>                          | 25% <u>coinsurance</u> (facility fees)/ 10% <u>coinsurance</u> (professional fees & ancillary fees) | <u>Preauthorization</u> required.  |
| If you are pregnant   | Office visits                             | 10% <u>coinsurance</u>                          | 10% <u>coinsurance</u>  | <u>Preauthorization</u> required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). 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 newborn is subject to their own <u>deductible</u> . |
|   | Childbirth/delivery professional services | 10% <u>coinsurance</u>                          | 10% <u>coinsurance</u>  |  |
|   | Childbirth/delivery facility services     | 10% <u>coinsurance</u>                          | 25% <u>coinsurance</u>  |  |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | 10% <u>coinsurance</u>                          | 10% <u>coinsurance</u>  | Limited to 130 visits per year and 4 hours per visit.  |
|   | <u>Rehabilitation services</u>            | 10% <u>coinsurance</u>                          | 10% <u>coinsurance</u> (professional or outpatient ancillary)/ 25% <u>coinsurance</u> (hospital)    | Occupational and speech therapy are not covered unless part of <u>home health care</u> .   |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                  |   | Limitations, Exceptions, & Other Important Information   |
|--|----------------------------------|--|---|--|
|  |                                  | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |  |
|  | <u>Habilitation services</u>     | Not Covered  | Not Covered   | This exclusion will not apply to expenses that are considered mental health or substance abuse services. |
|  | <u>Skilled nursing care</u>      | Not Covered  | Not Covered   | Not Covered  |
|  | <u>Durable medical equipment</u> | 10% <u>coinsurance</u>                             | 10% <u>coinsurance</u>                                | Any purchase requires written approval.  |
|  | <u>Hospice services</u>          | Not Covered  | Not Covered   | Bereavement counseling is also not covered.  |
| If your child needs dental or eye care | Children's eye exam              | 10% <u>coinsurance</u>                             | 10% <u>coinsurance</u>                                | Limited to 1 exam per year.  |
|  | Children's glasses               | 10% <u>coinsurance</u>                             | 10% <u>coinsurance</u>                                | Limited to 1 set of frames per year.   |
|  | Children's dental check-up       | No Charge  | No Charge   | Limited to 2 check-ups per year. Separate dental <u>deductible</u> does not apply.                       |

**Excluded Services & Other Covered Services:**

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Bereavement counseling</li> <li>• Cosmetic surgery</li> </ul>                                    | <ul style="list-style-type: none"> <li>• Habilitation services</li> <li>• Hospice services</li> <li>• Infertility treatment (except diagnosis)</li> <li>• Long-term care</li> </ul>              | <ul style="list-style-type: none"> <li>• Routine foot care (except for metabolic or peripheral vascular disease)</li> <li>• Skilled nursing care</li> <li>• Weight loss programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                    |  |   |
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Chiropractic care</li> <li>• Dental care (Adult &amp; Child-2 check-ups per year)</li> </ul>           | <ul style="list-style-type: none"> <li>• Glasses (Adult &amp; Child - 1 set of frames per year)</li> <li>• Hearing aids</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing (when <u>medically necessary</u>)</li> <li>• Routine eye care (Adult &amp; Child - 1 exam per year)</li> </ul>                |

**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](http://www.cciio.cms.gov), or Valdez City Schools at (907) 834-4700. 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](http://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 on how 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 Valdez City Schools at (907) 834-4700 or Meritain Health, Inc. at (866) 808-2609.

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, 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 \$100
- Primary care physician coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This **EXAMPLE** event includes services like:

Primary care physician visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$100        |
| Copayments                        | \$0          |
| Coinsurance                       | \$400        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$548</b> |

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

- The plan's overall deductible \$100
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This **EXAMPLE** event includes services like:

Specialist office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$100        |
| Copayments                        | \$200        |
| Coinsurance                       | \$200        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$20         |
| <b>The total Joe would pay is</b> | <b>\$508</b> |

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

- The plan's overall deductible \$100
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$100        |
| Copayments                        | \$10         |
| Coinsurance                       | \$300        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$410</b> |

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