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 or by calling 907-424-6223.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** person / **$4,500** family Network providers, **$1,500** person / **$4,500** family non-Network providers. Doesn't apply to Network physician office visits. Copayments; prior authorization and cost containment penalties; premiums don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this health insurance 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 titled Common Medical Event for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart titled Common Medical Event for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$4,000** person / **$12,000** family Network providers, **$4,000** person / **$12,000** family non-Network providers.	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?	Premiums, prior authorization and cost containment penalties, amounts over allowed amount, (balance-billed charges for non-Network providers) 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.	
Does this plan use a network of providers?	Yes. For a list of Network Providers, see www.fchn.com or call 800-467-5281.	If you use a Network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Beware, your Network **provider** may use an out-of-Network **provider** for some services. Plans use the term panel, in-network, preferred, or participating for **providers** in their **network**. See the chart titled Common Medical Event for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
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 in the box titled Services Your Plan Does Not Cover. See your policy or plan document for information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network 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 Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 for first 6 visits, subject to 20% coinsurance after 6th visit copay/visit	$25 for first 6 visits, subject to 20% coinsurance after 6th visit copay/visit	---------- none ----------
	Specialist visit	$25 for first 6 visits, subject to 20% coinsurance after 6th visit copay/visit	$25 for first 6 visits, subject to 20% coinsurance after 6th visit copay/visit	---------- none ----------
	Other practitioner office visit	Spinal manipulation, Acupuncture: $25 copay	Spinal manipulation, Acupuncture: $25 copay	24 Chiropractic visits PCY 12 Acupuncture visits PCY
	Preventive care / screening / immunization	0% coinsurance	20% coinsurance	---------- none ----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	---------- none ----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered benefits.
If you need drugs to treat your illness or condition More information about **prescription**	Generic drugs	At pharmacy: $10 copay Mail order: $20 copay	Coverage for ingredient costs and dispensing fees only.	---------- none ----------
	Preferred brand drugs	At pharmacy: $20 copay Mail order: $40 copay	Coverage for ingredient costs and dispensing fees only.	---------- none ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
drug coverage is available at **mycatamaranrx.com**	Non-preferred brand drugs	At pharmacy: $40 copay Mail order: $80 copay	Coverage for ingredient costs and dispensing fees only.	---------- none ----------
	Specialty drugs	Mail order: $40, max of 30 day supply copay		---------- none ----------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered benefits.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered benefits.
If you need immediate medical attention	Emergency room services	For medical emergency only: $100 copay 20% coinsurance	For medical emergency only: $100 copay 40% coinsurance	Non-emergency medical care not covered.
	Emergency medical transportation	$100 copay 20% coinsurance	$100 copay 40% coinsurance	
	Urgent care	$25 for first 6 visits, subject to 20% coinsurance after 6th visit copay/visit	$25 for first 6 visits, subject to 20% coinsurance after 6th visit copay/visit	---------- none ----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered services.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	---------- none ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health Outpatient services	Office visits: $25 copay for first 6 visits Intermediate care: 20% coinsurance	Office visits: $25 copay for first 6 visits Intermediate care: 20% coinsurance	
	Mental/Behavioral health Inpatient services	20% coinsurance	20% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered services.
	Substance use disorder Outpatient services	Office visits: 20% coinsurance Intermediate care: 20% coinsurance	Office visits: 20% coinsurance Intermediate care: 20% coinsurance	
	Substance use disorder Inpatient services	20% coinsurance	20% coinsurance	Prior authorization required Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered services.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered services.
	Rehabilitation services	Occupational Therapy: 20% coinsurance **OR** Speech Therapy: 20% coinsurance **OR** Physical Therapy: 20% coinsurance	Occupational Therapy: 20% coinsurance **OR** Speech Therapy: 20% coinsurance **OR** Physical Therapy: 20% coinsurance	
	Habilitation services			Not covered

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	20% coinsurance	20% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered services. Coverage limited to 60 days per Calendar Year for Network Provider. Coverage limited to 60 days per Calendar Year for non-Network Provider.
	Durable medical equipment	20% coinsurance	20% coinsurance	Prior authorization required. Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered services.
	Hospice service	20% coinsurance 130 days Outpatient Lifetime maximum 10 days inpatient, 130 days outpatient Outpatient and inpatient Lifetime maximum	40% coinsurance 130 days Outpatient Lifetime maximum 10 days inpatient, 130 days outpatient Outpatient and inpatient Lifetime maximum	Prior authorization required. Penalties for failure to get prior authorization: allowed amount reduced to 50% of covered services.
If your child needs dental or eye care	Eye exam	$25 copay	$25 copay	1 per Calendar year
	Glasses (frames & lenses) and Contact Lenses	$500 max benefit	$500 max benefit	$500 combined benefit per Calendar year
	Dental check-up			Benefit limited to 2 exam(s) every calendar year $2000 maximum benefit per year

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.)

- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. if travel is for the sole purpose of obtaining medical services
- Private-duty nursing
- 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.)

- Chiropractic care
- Dental care (Adult)
- Routine eye care (Adult)

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 907-424-6223. 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: the plan sponsor at **907-424-6223** or the plan's Claims administrator at 800-982-2012, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 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.

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 also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7540
- **Plan pays** $0
- **Patient pays** $0

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$**

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

- **Amount owed to providers:** $5400
- **Plan pays** $0
- **Patient pays** $0

Sample care costs:

Prescriptions	$2900
Medical Equipment & Supplies	$1300
Office visits & Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$**

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.
- 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 in-network **providers**. If the patient had received care from out-of-network **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 for 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.