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, Integrity Administrators at 800-562-9383. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://aspe.hhs.gov/glossary-terms or call 1-800-562-9383 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150/individual; $300/family** for network providers and out-of-network providers combined.	Generally, you must pay all $150 of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes. Deductible does not apply to preadmission testing, birthing center, home healthcare, hospice care, skilled nursing facility and preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive care services at 100%.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network providers **$500 individual / $1500 family**; for out-of-network facilities there is no maximum.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.fchn.com or call 1-800-231-6935 for a list of network providers.	This plan uses a provider network for hospital services. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	This plan will pay some or all of the costs to see a specialist for covered services.

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
		Network Provider (You will pay the least)	Non-Alaska Out of Network Provider (You will pay less than Out of Network Providers)	Alaska Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary care visit to treat an injury or illness	10% coinsurance	10% coinsurance	None
	Specialist visit	10% coinsurance	10% coinsurance	10% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance (professional and facility)	10% coinsurance (professional) and 30% coinsurance (facility)	10% coinsurance (professional) and 40% (facility)	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance (professional and facility)	10% coinsurance (professional) and 30% coinsurance (facility)	10% coinsurance (professional) and 40% (facility)	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$10 copay/prescription - retail; $0 copay/ prescription - mail	Not covered	Not covered	Covers up to a 120-day supply – retail and mail order.
	Preferred brand drugs	$20 copay/ prescription - retail; $0 copay/ prescription - mail	Not covered	Not covered	
	Non-preferred brand drugs	$40 copay/ prescription – retail; $0 copay/ prescription - mail	Not covered	Not covered	
	Specialty drugs	$20 copay/ prescription – retail; $0 copay/ prescription - mail	Not covered	Not covered	
	Brand drugs when no generic substitute is available	$20 copay/ prescription – retail; $0 copay/ prescription mail	Not covered	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.integrityadmin.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Alaska Out of Network Provider (You will pay less than Out of Network Providers)	Alaska Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	$200 copay then 40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	10% coinsurance	10% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	10% coinsurance	Out of network provider must meet the plan's definition of an emergency. Air transportation requires pre-authorization form be completed.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	10% coinsurance	10% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	$200 copay then 40% coinsurance	Call Hines & Assoc. at (800) 559-3257 for pre-authorization. Failure to do so may result in $250 penalty.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	10% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	10% coinsurance	10% coinsurance	Does not apply to out of pocket.
	Inpatient services	10% coinsurance	10% coinsurance – professional 30% coinsurance – facility	10% coinsurance – professional and $200 copay then 40% (facility)	Call Hines & Assoc. at (800) 559-3257 for pre-authorization. Failure to do so may result in $250 penalty.
If you are pregnant	Office visits	10% coinsurance	10% coinsurance	10% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	10% coinsurance	
	Childbirth/delivery facility	10% coinsurance	30% coinsurance	$200 copay then	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Alaska Out of Network Provider (You will pay less than Out of Network Providers)	Alaska Out-of-Network Provider (You will pay the most)	
	services			40% coinsurance	Maternity care does not apply to dependent children.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	No charge	100 visits per calendar year. Call Hines & Assoc. at (800) 559-3257 for pre-authorization. Failure to do so may result in $250 penalty.
	Rehabilitation services	10% coinsurance	10% coinsurance	10% coinsurance	None
	Habilitation services	Not covered	Not covered	Not covered	None
	Skilled nursing care	No charge	No charge	No charge	90 days per calendar year. Call Hines & Assoc. at (800) 559-3257 for pre-authorization. Failure to do so may result in $250 penalty.
	Durable medical equipment	10% coinsurance	10% coinsurance	10% coinsurance	None
	Hospice services	10% coinsurance	10% coinsurance	10% coinsurance	Call Hines & Assoc. at (800) 559-3257 for pre-authorization. Failure to do so may result in $250 penalty.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	Under vision benefits one per calendar year.

* For more information about limitations and exceptions, see the plan or policy document at www.integrityadmin.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Alaska Out of Network Provider (You will pay less than Out of Network Providers)	Alaska Out-of-Network Provider (You will pay the most)	
	Children's glasses	No charge	No charge	No charge	Under vision benefits one pair of lenses per calendar year and one frame per 24 month period.
	Children's dental check-up	30% first year; 20% second year; 10% third year; and no charge 4th year and after.	30% first year; 20% second year; 10% third year; and no charge 4th year and after.	30% first year; 20% second year; 10% third year; and no charge 4th year and after.	Covered under dental benefits.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Habilitation Services
- Bariatric Surgery
- Maternity Care for Dependent Children
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture – Must be ordered by an MD or DO and in lieu of general anesthesia
- Dental Care (Adult and Children) – covered under dental benefits
- Vision Care (Adult and Children) – covered under vision benefits.
- Chiropractic Care
- Annual pap smear
- Cosmetic Surgery – when it is due to an accidental injury which occurred while the patient was covered under the plan and services are within 12 months of accident; or when needed to correct a congenital abnormality in a child who has been covered since birth; and when necessary following surgery.
- Hearing Aids – Maximum of $400 per 36 month period and one hearing aid.
- Travel Services – commercial airline transportation and air ambulance is covered for life endangering situations; surgery that cannot be performed locally; and for a condition that cannot be treated locally. Travel services require written certification by the attending physician and travel pre-authorization form to be submitted. Please refer to your plan document for all

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

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: Alaska Department of Health and Social Services at (800) 478-2221. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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: Integrity Administrators, ATTN: Appeals, PO Box 13128, Sacramento, CA 95813-3128 (800) 562-9383

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 1-800-562-9383

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	$150
Specialist cost sharing	10%
Hospital (facility) cost sharing	10%
Other cost sharing	10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$150
Copayments	$10
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$620**

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

The plan's overall deductible	$150
Specialist cost sharing	10%
Hospital (facility) cost sharing	10%
Other cost sharing	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$150
Copayments	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,070**

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

The plan's overall deductible	$150
Specialist cost sharing	10%
Hospital (facility) cost sharing	10%
Other cost sharing	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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$150
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$460**

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