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, contact TPSC at (800) 426-9786 or visit us at **www.tpscbenefits.com**. 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.dol.gov/ebsa/healthreform** or **www.cciio.cms.gov**, or call TPSC at (800) 426-9786 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** individual/ **$300** family	Generally, you must pay all 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. Preventive care and prescription drugs are covered before you meet your deductible.	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 services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical expenses: **$1,100** individual/ **$3,300** family For prescription drugs: **$2,000** individual/ **$4,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, each family member has to meet his own out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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 preferred provider?	Yes. For a list of preferred providers, see http://www.fchn.com or call (800) 231-6935. For emergencies when traveling, see http://www.myfirsthealth.com or call (800) 226-5116.	This plan uses a provider network. 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 preferred 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.	You can see the specialist you choose without a referral.

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
		Preferred Provider (You will pay the least)	Non-Preferred 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	$10 copay, then 10% coinsurance/office visit	$10 copay, then 30% coinsurance/office visit	Primary or urgent care telemedicine visits are also covered at no charge through *Teladoc only*.
	Specialist visit			
	Preventive care/screening/immunization	No charge	30% coinsurance	Deductible is waived. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com. If receiving specialty drugs, enroll in the PrudentRx Copay Program by calling (800) 578-4403 for assistance.	Generic drugs	Retail: $14 copay/ prescription Mail Order: $24 copay/ prescription	Retail: 50% coinsurance Mail Order: Not covered	Deductible is waived. Retail is limited to a 34-day supply. Mail Order is limited to a 90-day supply and must be purchased through CVS Mail Services. If you use a non-preferred provider, you must pay 100% of cost at purchase; then submit claim for reimbursement. Limited to CVS' allowed amount for the prescription less applicable coinsurance. Certain preventive care medications are covered at no cost-sharing.
	Preferred brand drugs	Retail: $28 copay/ prescription Mail Order: $50 copay/ prescription	Retail: 50% coinsurance Mail Order: Not covered	
	Non-preferred brand drugs	Retail: $43 copay/ prescription Mail Order: $75 copay/ prescription	Retail: 50% coinsurance Mail Order: Not covered	
	Specialty drugs	No charge	Not covered	Coverage is limited to a 34-day supply and provided at no charge if enrolled in the PrudentRx Copay Program. If not enrolled, the cost is 30% coinsurance. All refills must be purchased through CVS Specialty Pharmacy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$75 copay, then 10% coinsurance/visit		If you are admitted to the hospital from the emergency room, notify AHH as soon as possible at (888) 877-7994.
	Emergency medical transportation	20% coinsurance		None
	Urgent care	$10 copay, then 10% coinsurance/office visit	$10 copay, then 30% coinsurance/office visit	Primary or urgent care telemedicine visits are also covered at no charge through *Teladoc only*.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	If your doctor recommends Inpatient treatment, notify AHH at (888) 877-7994 at least 48 hours before admission.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay, then 10% coinsurance/office visit	$10 copay, then 30% coinsurance/office visit	None
	Inpatient services	10% coinsurance	30% coinsurance	If your doctor recommends Inpatient treatment, notify AHH at (888) 877-7994 at least 48 hours before admission.
If you are pregnant	Office visits	$10 copay, then 10% coinsurance/first office visit only	$10 copay, then 30% coinsurance/first office visit only	Some prenatal services are covered preventive care and available to all covered persons. Cost sharing does not apply to preventive care. Depending on the type of services, copays or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage is limited to 130 visits/year.
	Rehabilitation services	10% coinsurance	30% coinsurance	Limited to 40 outpatient visits/year. Inpatient services are limited to 15 days/ year.
	Habilitation services	10% coinsurance	30% coinsurance	Limited to 40 outpatient visits/year. No visit limits for children through age 6. Inpatient services are limited to 15 days/ year.
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 90 days/year.
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance		Limited to 6 months of care/year.
If your child needs dental or eye care	Children's eye exam	Not covered		Not covered under this Medical Plan.
	Children's glasses	Not covered		Not covered under this Medical Plan.
	Children's dental check-up	Not covered		Not covered under this Medical Plan.

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental care (Adult)
- Infertility Treatment
- Long-Term Care
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- Non-emergent care when traveling outside the U.S.

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

- Acupuncture
- Chiropractic Care
- Hearing Aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at (877) 267-2323 x61565 or www.cciio.cms.gov. 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 (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: TPSC at (800) 426-9786 or visit us at www.tpscbenefits.com. Additionally, a consumer assistance program can help you file your appeal. Contact the Washington State Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Tumwater, WA 98501, at (800) 562-6900 or (360) 725-7080 [TDD:(360) 586-0241]; http://www.insurance.wa.gov; or email cap@oic.wa.gov.

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 (800) 426-9786.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 426-9786.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 426-9786.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 426-9786.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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**
Specialist coinsurance	**$10**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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	$100
Copayments	$70
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,370**

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:
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	$100
Copayments	$600
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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