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?	**$50** individual / **$150** 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. Office visits, preventive care, hospitalization, diagnostic tests, emergency 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: **$425** individual / **$1,275** 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 network 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
		Employees	Dependents	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	No charge	Deductible waived for employees and dependents. Primary or urgent care telemedicine visits are also covered at no charge through *Teladoc only*.
	Specialist visit			
	Preventive care/screening/ immunization	No charge	No charge	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)	No charge	No charge	Deductible waived for employees. Deductible is waived for tests due to Dependent's Injury. *If tests are due to Dependent's Illness, paid in full up to $100, then 80% coinsurance after deductible.
	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. *(cont'd next page)*	Generic drugs	Preferred providers: Retail: No charge Mail Order: No charge Non-preferred providers: Retail: No charge Mail Order: Not covered	Preferred provider: Retail: $10 copay/Rx Mail Order: $20 copay/Rx Non-preferred providers: 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. ***Note:*** *LEOFF I retirees' dependents age 65 and over are not eligible for Prescription Drug coverage.*
	Preferred brand drugs	Preferred providers: Retail: No charge Mail Order: No charge Non-preferred providers: Retail: No charge Mail Order: Not covered	Preferred provider: Retail: $15 copay/Rx Mail Order: $30 copay/Rx Non-preferred providers: Retail: 50% coinsurance Mail Order: Not covered	
	Non-preferred brand drugs			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Employees	Dependents	
Prescription drug coverage *(cont'd)* If receiving specialty drugs, enroll in the PrudentRx Copay Program by calling (800) 578-4403.	Specialty drugs	Preferred providers: No charge Non-preferred providers: Not covered	PrudentRx Enrollees: No charge Non-participating Members: 30% coinsurance Non-preferred providers: Not covered	Coverage is limited to a 34-day supply. All refills must be purchased through CVS Specialty Pharmacy. Dependents: If enrolled in the PrudentRx Copay Program, drugs are provided at no charge. If not enrolled, the cost is 30% coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		Deductible is waived.
	Physician/surgeon fees	No charge		Deductible is waived for employees only.
If you need immediate medical attention	Emergency room care	No charge	$50 copay/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	Paid in full up to $150, then 20% coinsurance		Deductible is waived for first $150, then deductible and coinsurance apply to the remaining expenses.
	Urgent care	No charge		Deductible waived for employees and dependents. 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)	No charge for first 365 days/lifetime, then 20% coinsurance		Deductible is waived for first 365 days/ lifetime. If your doctor recommends Inpatient treatment, notify AHH at (888) 877-7994 at least 48 hours before admission.
	Physician/surgeon fees	No charge		Deductible is waived for employees only.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Employees	Dependents	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge		Deductible is waived.
	Inpatient services	No charge		Deductible is waived. Intensive outpatient treatment or a partial confinement facility costs the same as other Inpatient services. If your doctor recommends Inpatient treatment, notify AHH at (888) 877-7994 at least 48 hours before admission.
If you are pregnant	Office visits	No charge		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	No charge		
	Childbirth/delivery facility services	No charge		
If you need help recovering or have other special health needs	Home health care	No charge		Deductible is waived. Coverage is limited to130 visits/year.
	Rehabilitation services	No charge		Deductible is waived.
	Habilitation services	No charge		Deductible is waived.
	Skilled nursing care	No charge		Deductible is waived for employees only. Limited to 365 days/lifetime.
	Durable medical equipment	20% coinsurance		None
	Hospice services	No charge		Deductible is waived. 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**	**$50**
■ **Specialist coinsurance**	**0%**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

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	$50
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$50**

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

■ **The plan's overall deductible**	**$50**
■ **Specialist coinsurance**	**0%**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

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	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$50**

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

■ **The plan's overall deductible**	**$50**
■ **Specialist coinsurance**	**0%**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

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	$50
Copayments	$60
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$310**

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