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?	For preferred providers: **$1,000** individual/ **$2,000** 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, office visits and lab work 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?	Yes. Prescription drugs: **$100** individual/ **$300** family There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. 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.
What is the out-of-pocket limit for this plan?	For preferred providers: Medical: **$5,000** individual/ **$10,000** family, includes maternity out-of-pocket limit of **$3,000** individual/ family For non-preferred provider: Medical: **$7,500** Individual/ **$15,000** family Prescription drugs: **$1,850** individual/ **$3,700** family	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, 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.

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Important Questions	Answers	Why This Matters:
Will you pay less if you use a preferred provider?	Yes. For a list of preferred providers, see www.fchn.com or call (800) 231-6935. For emergencies when traveling, see www.multiplan.com/search or call (800) 678-7427.	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	$25 copay/office visit	40% coinsurance	Deductible waived for preferred providers. No charge for lab work and X-rays performed during an office visit with a preferred provider.
	Specialist visit	$50 copay/office visit	40% coinsurance	
	Preventive care/screening/immunization	No charge	40% coinsurance	Deductible waived for preferred providers. You may have to pay for services that aren't preventive. Birth control drugs, devices and counseling are not covered. 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)	Lab Work: No charge Radiology: 20% coinsurance	40% coinsurance	Deductible waived for Lab Work at preferred provider Hospital Outpatient or independent facilities. Payment may differ based on place of service. Inpatient diagnostic services are paid at 20%/40% coinsurance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.maxor.com.	Generic drugs	Retail: $10 copay/prescription Mail Order: $25 copay/prescription	Retail: $10 copay plus 20% coinsurance Mail Order: Not covered	Retail: Limited to a 30-day supply. Mail Order: Limited to a 90-day supply. Mail Order is available only through Maxor Mail Order Pharmacy. At a non-preferred pharmacy, you must pay 100% of cost at time of purchase; then submit claim for reimbursement. Limited to Maxor's allowed amount for the drug less applicable copay and coinsurance. Certain medications are covered at no cost under preventive care with a written prescription.
	Preferred brand drugs (Formulary)	Retail: $25 copay/prescription Mail Order: $60 copay/prescription	Retail: $25 copay plus 20% coinsurance Mail Order: Not covered	
	Non-preferred brand drugs (Non-Formulary)	Retail: $50 copay/prescription Mail Order: $125 copay/prescription	Retail: $50 copay plus 20% coinsurance Mail Order: Not covered	
	Specialty drugs — Generic	10% coinsurance/maximum $150/Prescription		Coverage is limited to a 30-day supply.
	Specialty drugs — Formulary	20% coinsurance/maximum $150/Prescription		
	Specialty drugs — Non-Formulary	20% coinsurance/maximum $250/Prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	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	20% coinsurance	None
	Urgent care	$25 copay/office visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	If your doctor recommends Inpatient treatment, notify AHH at least 48 hours before admission at (888) 877-7994.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

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 mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/office visit	40% coinsurance	Deductible waived for preferred providers.
	Inpatient services	20% coinsurance	40% coinsurance	If your doctor recommends Inpatient treatments, notify AHH at least 48 hours before admission at (888) 877-7994.
If you are pregnant	Office visits	$25 copay/initial office visit; deductible waived	40% coinsurance	Some prenatal services are covered preventive care services and available to all covered persons. Cost-sharing does not apply to preventive care. Only employees and spouses are covered for all other maternity services. 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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to100 visits/year.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 120 days per Illness or Injury.
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes vehicle or home modifications, exercise or bathroom equipment.
	Hospice services	20% coinsurance	40% coinsurance	Limited to 180 days/year.
If your child needs dental or eye care	Children's eye exam	Not covered under this Medical Plan.		Not covered under this Medical Plan.
	Children's glasses			
	Children's dental check-up			

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.)

- Abortion, Contraceptives, or Sterilization
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult & Child)
- Hearing Aids
- Infertility Treatment (except initial diagnosis)
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care (Adult & Child)
- 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
- Chiropractic Care
- Non-emergent care when traveling outside the U.S. for the Employer

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at: TPSC at (800) 426-9786 or visit us at www.tpscbenefits.com. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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; or the U.S. Department of Labor's Employee Benefit Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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.

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	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,040
Copayments	$150
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,500**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,100
Copayments	$940
Coinsurance	$350
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,390**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$150
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,480**

*This amount includes both Medical and Prescription Drug Deductibles ($1,000 + $100).

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