This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.trusteedplans.com or by calling 1-800-426-9786.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$750 person/$2,250 family. Does not apply to preventive care, outpatient prescription drugs and vision services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 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 starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $3,750 person/$11,250 family. For outpatient prescription drugs: $1,000 person/$2,000 family.	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, balance-billed charges, healthcare this plan doesn't cover, and vision hardware ("for all others") coinsurance.	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	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of Preferred Providers, see www.fchn.com or call (800) 231-6935. For emergencies when traveling, see www.myfirsthealth.com or call (800) 226-5116.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
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 on page 5. See your plan document for additional 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 preferred providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/Visit, then 20% Coinsurance	$25/Visit, then 40% Coinsurance	-----none-----
	Specialist visit	$50/Visit, then 20% Coinsurance	$50/Visit, then 40% Coinsurance	-----none-----
	Other practitioner office visit	$25/Visit, then 20% Coinsurance	$25/Visit, then 40% Coinsurance	Acupuncture is limited to 16 visits/year; chiropractic care is limited to 30 visits/year; massage therapy is limited to 16 visits/year.
	Preventive care/screening/immunization	No charge	40% Coinsurance	Deductible waived.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.maxor.com/maxorplus.	Generic drugs	Retail: $15/Prescription Mail-Order: $30/Prescription	Retail: 50% Coinsurance** Mail-Order: Not Covered	Deductible waived for all drugs. Preferred Providers: Retail: Limited to a 34-day supply. Mail-order: Limited to a 90-day supply. Non-Preferred Providers: Retail: Limited to a 34-day supply. **You must pay 100% of cost at time of purchase; then submit claim for reimbursement. Limited to MaxorPlus' Maximum Allowable Charge for the drug less applicable coinsurance. Mail-Order: No coverage for Non-Preferred Providers.
	Preferred brand drugs	Retail: $30/Prescription Mail-Order: $60/Prescription		
	Non-preferred brand drugs	Retail: $30/Prescription Mail-Order: $60/Prescription		
	Specialty drugs	Same as any other drug	Not covered	Limited to a 34-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	-----none-----
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services	$125/Visit, then 20% Coinsurance		Copay is waived if admitted to Hospital.
	Emergency medical transportation	20% Coinsurance		-----none-----
	Urgent care	$25/Visit, then 20% Coinsurance	$25/Visit, then 40% Coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	-----none-----
	Physician/surgeon fee			-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25/Visit, then 20% Coinsurance	40% Coinsurance	-----none-----
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	-----none-----
	Substance use disorder outpatient services	$25/Visit, then 20% Coinsurance	40% Coinsurance	-----none-----
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	-----none-----

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$25/Visit, then 20% Coinsurance	$25/Visit, then 40% Coinsurance	Limited to employee & spouse only.
	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	Limited to 130 visits/year.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	Inpatient: Limited to 15 days/year. Outpatient: Limited to 40 visits/year.
	Habilitation services	20% Coinsurance	40% Coinsurance	Inpatient: Limited to 15 days/year. Outpatient: Limited to 40 visits/year. No visit limits for children through age 6.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Limited to 90 days/year.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	-----none-----
	Hospice service	20% Coinsurance		Limited to 6 mo. of care/ year.
If your child needs dental or eye care	Eye exam	No charge		Limited to 1 exam/year.
	Glasses	20% Coinsurance		Limited to 1 pair/2 years.
	Dental check-up	Not covered		This Plan does not cover dental care.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic Care
- Hearing Aids
- Routine Eye Care (Adult & Child)

Questions: Call 1-800-426-9786 or visit us at www.trusteedplans.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-426-9786 to request a copy.

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: TPSC at (800) 426-9786 or visit us at www.trusteedplans.com. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, 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: TPSC at (800) 426-9786 or visit us at www.trusteedplans.com; or refer to the appeals processes in the CLAIMS PROCEDURES section of your plan document. You may also contact the U.S. Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-426-9786.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-426-9786.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-426-9786.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-426-9786.

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 will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $5,380
- Patient pays $2,160

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$750
Copays	$80
Coinsurance	$1,300
Limits or exclusions	$30
Total	$2,160

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

- Amount owed to providers: $5,400
- Plan pays $3,600
- Patient pays $1,800

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$750
Copays	$790
Coinsurance	$220
Limits or exclusions	$40
Total	$1,800

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 in 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.