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, call 503-353-6000, ext. 36026. 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 call 503-353-6000, ext. 36026 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 per person for Preferred Network. $250 per person for Participating & Out-of-Network.	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. Cologuard medical & preventive and titer test for all Networks. Air ambulance, ambulance, breast pumps, cabulance, chiropractic services, emergency room, flu shots, immunizations, transplant expenses (travel, meals, lodging), urgent care and wigs for Participating & Out-of-Network. Preventive care & services for Participating Network.	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. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$700 person/$2,100 family for Preferred Network. $2,100 person/$6,300 family for Participating & Out-of-Network. Amounts credited to the Preferred Network and Participating Network/Out-of-Network cross accumulate. $5,050 person/$8,000 family for Pharmacy.	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?	Penalties, ineligible charges, premiums, balance-billed 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.accesshma.com or call 1-800-700-7153 for a list of network providers.	You pay the least if you use a provider in the Preferred Network. You pay more if you use a provider in the Participating 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.	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)	Participating Provider	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	$15/visit	25% coinsurance	25% coinsurance	————none————
	Specialist visit	$15/visit	25% coinsurance	25% coinsurance	————none————
	Preventive care/screening/ immunization	No charge	No charge, deductible does not apply	$15/visit, deductible does not apply for immunizations (waived if office visit/visit is applied), otherwise not covered	Preventive gynecological exams are limited to one exam per calendar year. Preventive prostate exams are limited to one exam every 24 months for individuals age 50 and older. Preventive mammography is limited to one baseline for individuals age 35-40 and once per calendar year for age 40 and older. Wellness visits & services limited to 8 exams up to age 2, one exam per calendar year from age 2 to 7, one exam every 24 months age 7 to 19, one exam every 36 months age 19 to 35, one exam every 24 months age 35 to 50 and one exam per year age 50 and over. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for.

[* For more information about limitations and exceptions, see the plan or policy document at www.nclack.k12.or.us.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	25% coinsurance	25% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	No charge	25% coinsurance	25% coinsurance	————none————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	$10 copay for retail; $20 copay for mail order			Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred brand drugs	$20 copay for retail; $40 copay for mail order			
	Non-preferred brand drugs	30% coinsurance			
	Specialty drugs	Covered			Please contact CVS Caremark, your specialty pharmacy for more information on what is covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	25% coinsurance	25% coinsurance	Preauthorization is required.
	Physician/surgeon fees	No charge	25% coinsurance	25% coinsurance	————none————
If you need immediate medical attention	Emergency room care	$105/visit	$105/visit, deductible does not apply	$105/visit, deductible does not apply	Copay waived if admitted.
	Emergency medical transportation	$55/visit	$55/visit, deductible does not apply	$55/visit, deductible does not apply	————none————
	Urgent care	$55/visit	$55/visit, deductible does not apply	$55/visit, deductible does not apply	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	25% coinsurance	25% coinsurance	Preauthorization is required.
	Physician/surgeon fees	No charge	25% coinsurance	25% coinsurance	————none————

[* For more information about limitations and exceptions, see the plan or policy document at www.nclack.k12.or.us.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Facility: No charge Professional: $15/visit	25% coinsurance	25% coinsurance	Family, marital, and sexual counseling are not covered.
	Inpatient services	No charge	25% coinsurance	25% coinsurance	Preauthorization is required. Residential treatment is covered.
If you are pregnant	Office visits	$30per pregnancy	25% coinsurance	25% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	25% coinsurance	25% coinsurance	————none————
	Childbirth/delivery facility services	No charge	25% coinsurance	25% coinsurance	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be preauthorized at the time your provider recommends the extended stay.
If you need help recovering or have other special health needs	Home health care	$15/visit	25% coinsurance	25% coinsurance	Preauthorization is required. Preferred Network copay waived for first 5 visits.
	Rehabilitation services	No charge for inpatient; $15/visit for outpatient	25% coinsurance	25% coinsurance	Preauthorization is required for inpatient and is limited to 30 days per calendar year, with an additional 30 days for the treatment of stroke, brain, or spinal cord injury. Outpatient is limited to 30 visits per calendar year with an additional 30 visits for the treatment of stroke, brain, or spinal cord injury. Swim therapy is not covered.
	Habilitation services	Not covered	Not covered	Not covered	Neurodevelopmental therapy is covered under outpatient rehabilitation with no age limit.
	Skilled nursing care	No charge	25% coinsurance	25% coinsurance	Preauthorization is required. Limited to 60 day per calendar year.
	Durable medical equipment	20% coinsurance	25% coinsurance	25% coinsurance	Preauthorization is required for equipment over $2,000.

[* For more information about limitations and exceptions, see the plan or policy document at www.nclack.k12.or.us.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	25% coinsurance	25% coinsurance	Preauthorization is required. Lifetime maximum 6 months.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	If enrolled, please refer to vision benefit booklets.
	Children's glasses	Not covered	Not covered	Not covered	If enrolled, please refer to vision benefit booklets.
	Children's dental check-up	Not covered	Not covered	Not covered	If enrolled, please refer to dental benefit booklets.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Family, marital, and sexual counseling
- Habilitation services
- Infertility treatment
- Long-term care
- Massage therapy
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except diabetes)
- Swim therapy
- Weight loss programs

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

- Chiropractic care (20 visit yearly limit)
- Hearing aids (dependent children only) (Limited to one hearing aid per ear every 48 months)
- Private-duty nursing (transplants only)

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: Peak 1, 1-877-404-9443, and the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 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 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 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: 1-800-700-7153, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

[* For more information about limitations and exceptions, see the plan or policy document at www.nclack.k12.or.us.]

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 1-800-700-7153.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-700-7153.]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-700-7153.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-700-7153.]

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

[* For more information about limitations and exceptions, see the plan or policy document at www.nclack.k12.or.us.]

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	$0
Specialist copayment	$15
Hospital (facility) coinsurance	00%
Other coinsurance	00%

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	$00
Copayments	$40
Coinsurance	$00
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$100

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	00%
Other coinsurance	00%

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	$00
Copayments	$600
Coinsurance	$00
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$620

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	00%
Other coinsurance	00%

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	$00
Copayments	$240
Coinsurance	$60
What isn't covered	
Limits or exclusions	$00
The total Mia would pay is	$300

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