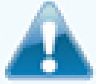
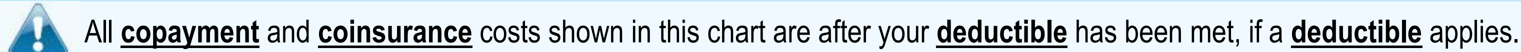


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call **1-503-588-6162** or visit www.ebms.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 https://www.healthcare.gov/sbc-glossary or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network provider/non-Network providers: $250 individual, $500 Employee +1, $750 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. Emergency room care, alternative care, prescription drugs, and network provider: urgent care, prenatal care, and preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, however 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?	Medical/network providers: $1,250 individual, $2,500 Employee +1, $3,750 family. Medical non-network providers: $2,250 individual, $4,500 Employee +1, $6,750 family. Prescription drugs: $2,000 individual, $4,000 Employee +1, $6,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members 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?	Infertility services, organ transplant services performed at a non-Center of Excellence facility, prescription drugs, premiums, balance-billing charges (unless balanced billing is prohibited), 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.fchn.com or call 1-800-231-6935 for a list of network providers.	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 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: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	Coverage limited to age and developmentally appropriate frequency limitations. **Note:** Not all routine services may qualify as preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com or call toll free: 1-888-543-1369.	Generic drugs (Tier 1)	*30-day retail:* $10 copayment; *31 to 90-day retail*: $30 copayment; *90-day mail order*: $20 copayment		The medical deductible does not apply to prescription drugs. The copayment amount applies per prescription. If you use a non-network Pharmacy, you will be required to pay 100% of the total cost at the point of sale and submit your claim for reimbursement consideration. Specialty drugs are limited to a 30-day supply per prescription.
	Preferred brand drugs (Tier 2)	*30-day retail*: 30% copayment, minimum of $25, maximum of $55; *31 to 90-day retail:* 30% copayment, minimum of $75, maximum of $165; *90-day mail order*: 30% copayment, minimum of $50, maximum of $110		
	Non-preferred brand drugs (Tier 3)	*30-day retail*: 30% copayment, minimum of $45, maximum of $75; *31 to 90-day retail:* 30% copayment, minimum of $135, maximum of $225; *90-day mail order*: 30% copayment, minimum of $90, maximum of $150		
	Specialty drugs (Tier 4)	*Generic:* $10 copayment; *Preferred brand drugs:* 30% copayment, minimum of $25, maximum of $55; *Non-preferred brand:* 30% copayment, minimum of $45, maximum of $75		

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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 Medical emergency services	$100 copayment per visit; deductible does not apply		The emergency room care copayment is waived if admitted to the hospital.
	Medical non-emergency services	$100 copayment per visit then 20% coinsurance; deductible does not apply	$100 copayment per visit then 40% coinsurance; deductible does not apply	
	Emergency medical transportation	20% coinsurance		None
	Urgent care	$50 copayment per visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification is required prior to an inpatient stay. Coverage is limited to the semi-private room rate.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Pre-certification is required prior to an inpatient stay.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Pre-certification is required for an inpatient stay that exceeds 48 hours following a vaginal delivery or 96 hours following a Cesarean section. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Prenatal services	No charge	40% coinsurance	
	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 to 180 visits per year. Pre-certification of home health care is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Pre-certification is required prior to an inpatient stay. Outpatient services are limited to 30 (combined) visits per year and include occupational, physical, speech, respiratory, aquatic, massage, pulmonary, respiratory,
	Habilitation services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				neurodevelopmental, and cardiac therapies.
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-certification is required prior to an inpatient stay. Coverage is limited to the semi-private room rate and 100 days per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-certification is required prior to purchase of any DME over $2,000 or any Prosthetic device over $1,000.
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Vision benefits may be available through a separate plan election.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge	40% coinsurance	Coverage is limited to preventive/routine dental exams only, for dependent children through age 18.

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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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
- Hearing aids
- Infertility treatment (treat cause & condition only)
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information, contact the plan at 1-503-588-6162 or these agencies: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/ or 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: EBMS at 1-800-777-3575 or the DOL's Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. Contact your state's program if available at: http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 1-866-887-4119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-887-4119.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-866-887-4119.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-887-4119.

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**	**$250**
■ **Specialist coinsurance**	**20%**
■ **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	$250
Copayments	$40
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,350**

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

■ **The plan's overall deductible**	**$250**
■ **Primary care physician coinsurance**	**20%**
■ **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	$250
Copayments	$310
Coinsurance	$1,660
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,275**

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

■ **The plan's overall deductible**	**$250**
■ **Specialist coinsurance**	**20%**
■ **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	$250
Copayments	$100
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$735**

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

NOTICE OF NONDISCRIMINATION OREGON

Your health plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your health plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact your Human Resources Department. If you believe that your health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator in the City Manager's Office, 555 Liberty St. SE, Room 220, Salem, OR 97301, phone#: 503-540-2371, TTY#: 503-588-6439, Fax: 503-588-6354, humanrights@cityofsalem.net.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

SPANISH
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-503-540-2371, TTY: 503-588-6439.

VIETNAMESE
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-503-540-2371, TTY: 503-588-6439.

CHINESE
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-503-540-2371, TTY: 503-588-6439. 。

RUSSIAN
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-503-540-2371, телетайп: 1-503-588-6439.

KOREAN
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-503-540-2371, TTY: 503-588-6439. 번으로 전화해 주십시오.

UKRAINIAN
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-503-540-2371, телетайп: 1-503-588-6439.

JAPANESE
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-503-540-2371, TTY: 503-588-6439, まで、お電話にてご連絡ください。

ARABIC
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-503-540-2371 (رقم هاتف الصم والبكم: 1-503-588-6439.

ROMANIAN
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-503-540-2371, TTY: 503-588-6439.

CAMBODIAN
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-503-540-2371, TTY: 503-588-6439.។

CUSHITE (written translated tagline is provided in the Oromo language)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-503-540-2371, TTY: 503-588-6439.

GERMAN
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-503-540-2371, TTY: 503-588-6439.

PERSIAN (written translated tagline is provided in the Farsi language)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-503-540-2371 (TTY: 1-503-588-6439) تماس بگیرید.

FRENCH
ATTENTION : Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-503-540-2371, ATS : 1-503-588-6439.

THAI
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-503-540-2371, TTY: 503-588-6439.