
 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms of the EAP by calling Teri Strong at (541) 345-2800 or (866) 293-4327, or at [tstrong@cascadehealth.org](mailto:tstrong@cascadehealth.org).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet <b>deductibles</b> 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?	No	There's no limit on how much you could pay during a coverage period for your share of the costs of covered services.
What is not included in the out-of-pocket limit?	This plan has no <b>out-of-pocket limit</b> .	Not applicable because there's no <b>out-of-pocket limit</b> on your expenses.
Is there an overall annual limit on what the plan pays?	Yes, up to 4 counseling sessions per problem per year	The plan will pay for covered services only up to this limit during each coverage period of, even if your own need is greater. The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	No	This plan treats <b>providers</b> the same in determining payment for the same services.
Do I need a referral to see a specialist?	No	You can see the <b>specialist</b> 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 4. See your policy or plan document for additional information about <b>excluded services</b> .

-  • **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**.)
- Your cost sharing does not depend on whether a **provider** is in a network.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Not covered	No coverage
	Specialist visit	Not covered	No coverage
	Other practitioner office visit	Not covered	No coverage
	Preventive care/screening/immunization	Not covered	No coverage
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	Not covered	No coverage
	Imaging (CT/PET scans, MRIs)	Not covered	No coverage
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	Not covered	No coverage
	Preferred brand drugs	Not covered	No coverage
	Non-preferred brand drugs	Not covered	No coverage
	Specialty drugs	Not covered	No coverage
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not covered	No coverage
	Physician/surgeon fees	Not covered	No coverage
<b>If you need immediate medical attention</b>	Emergency room services	Not covered	No coverage
	Emergency medical transportation	Not covered	No coverage
	Urgent care	Not covered	No coverage
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not covered	No coverage
	Physician/surgeon fee	Not covered	No coverage

<b>Common Medical Event</b>	<b>Services You May Need</b>	<b>Your Cost</b>	<b>Limitations &amp; Exceptions</b>
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Not covered	Up to 4 counseling sessions per problem per year
	Mental/Behavioral health inpatient services	Not covered	No coverage
	Substance use disorder outpatient services	Not covered	Up to 4 counseling sessions per problem per year
	Substance use disorder inpatient services	Not covered	No coverage
<b>If you are pregnant</b>	Prenatal and postnatal care	Not covered	No coverage
	Delivery and all inpatient services	Not covered	No coverage
<b>If you need help recovering or have other special health needs</b>	Home health care	Not covered	No coverage
	Rehabilitation services	Not covered	No coverage
	Habilitation services	Not covered	No coverage
	Skilled nursing care	Not covered	No coverage
	Durable medical equipment	Not covered	No coverage
	Hospice service	Not covered	No coverage
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	No coverage
	Glasses	Not covered	No coverage
	Dental check-up	Not covered	No coverage

### Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Chiropractic care</li><li>• Cosmetic surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
Employee assistance, including counseling services and referrals to other agencies or mental health professionals		

### Language Access Services

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íinízinigo t'áá diné k'éjígoo, t'áá shoodí ba na'aln'íhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalágú bich'í hodiilní. Hai'daa íini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki si'niilígú bí'kéhgo bich'í hodiilní.

### 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 may require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan (if any). Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan by calling **Teri Strong at (541) 345-2800 or (866) 293-4327**. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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 **Teri Strong at (541) 345-2800 or (866) 293-4327, or at [tstrong@cascadehealth.org](mailto:tstrong@cascadehealth.org)**. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

—————*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.

<b>Having a baby</b> (normal delivery)	<b>Managing type 2 diabetes</b> (routine maintenance of a well-controlled condition)
<ul style="list-style-type: none"> <li>■ <b>Amount owed to providers:</b> \$7,540</li> <li>■ <b>Plan pays:</b> These expenses are not covered under the plan.</li> </ul>	<ul style="list-style-type: none"> <li>■ <b>Amount owed to providers:</b> \$5,400</li> <li>■ <b>Plan pays:</b> These expenses are not covered under the plan.</li> </ul>

## 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.

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