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, go to PacificSource.com/plan-details. 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 Healthcare.gov/sbc-glossary or call 1-888-977-9299 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network provider: $2,500 individual/$5,000 family | Out-of-network provider: $7,500 individual/$15,000 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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and other services listed below with 'deductible does not apply'.	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 Healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network provider: $5,000 individual/$8,150 family | Out-of-network provider: $15,000 individual/$30,000 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, the overall family out-of-pocket limit must be 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.
Will you pay less if you use a network provider?	Yes. See providerdirectory.PacificSource.com/Commercial/?nPlan=Navigator or call 1-888-977-9299 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.

What You Will Pay				
Common Medical Event	**Services You May Need**	**In-network (You will pay the least)**	**Out-of-network (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	First three visits no charge. Subsequent visits, 20% co-insurance.	40% co-insurance	First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Specialist visit	20% co-insurance	40% co-insurance	None
	Preventive care/screening/immunization	No charge, deductible does not apply	40% co-insurance	Preventive Physicals: 13 visits ages 0-36 months, annually ages 3 and older. Well Woman Visits: annually. 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. Tobacco cessation: Not covered out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Prior authorization required. If not received, you will be responsible for the expense.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at PacificSource.com/drug-list	Generic drugs - Tier 1	Retail: 20% co-insurance Mail: 20% co-insurance	90% co-insurance	For all prescription drug list tiers: Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, deductible does not apply. Cost share amounts shown represent a 30 day supply at retail and a 90 day supply at mail order. Quantity for retail and mail order are limited to a 90 day supply. Quantity for Specialty drug is limited to 30 day supply. Prior authorization required for certain drugs. If not received, you will be responsible for the expense.
	Preferred drugs - Tier 2	Retail: 20% co-insurance Mail: 20% co-insurance	90% co-insurance	
	Non-preferred drugs - Tier 3	Retail: 20% co-insurance Mail: 20% co-insurance	90% co-insurance	
	Specialty drugs - Tier 4	Retail: 20% co-insurance Mail: 20% co-insurance	90% co-insurance	

What You Will Pay				
Common Medical Event	**Services You May Need**	**In-network (You will pay the least)**	**Out-of-network (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Prior authorization required for some surgeries. If not received, you will be responsible for the expense.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	None
If you need immediate medical attention	Emergency room care	Medical emergency: 20% co-insurance Non-emergency: 20% co-insurance	Medical emergency: 20% co-insurance Non-emergency: 40% co-insurance	None
	Emergency medical transportation	Ground: 20% co-insurance Air: 20% co-insurance	Ground: 20% co-insurance Air: 20% co-insurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	Urgent care	20% co-insurance	40% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Limited to semi-private room, except when a private room is determined to be necessary. Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First three visits no charge. Subsequent visits, 20% co-insurance.	40% co-insurance	First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Inpatient services	20% co-insurance	40% co-insurance	Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.
If you are pregnant	Office visits	20% co-insurance	40% co-insurance	Cost sharing does not apply for preventive services. Delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services.
	Childbirth/delivery professional services	20% co-insurance	40% co-insurance	
	Childbirth/delivery facility services	20% co-insurance	40% co-insurance	

What You Will Pay				
Common Medical Event	**Services You May Need**	**In-network (You will pay the least)**	**Out-of-network (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	No coverage for private duty nursing or custodial care.
	Rehabilitation services	Inpatient: 20% co-insurance Outpatient: 20% co-insurance	Inpatient: 40% co-insurance Outpatient: 40% co-insurance	Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	Habilitation services	Inpatient: 20% co-insurance Outpatient: 20% co-insurance	Inpatient: 40% co-insurance Outpatient: 40% co-insurance	Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	Skilled nursing care	20% co-insurance	40% co-insurance	Limited to 60 days/year. No coverage for custodial care.
	Durable medical equipment	20% co-insurance	40% co-insurance	Limited to: $5,000/year overall; one pair/year for glasses or contact lenses; one breast pump/pregnancy; $150/year for wig for chemotherapy or radiation therapy. Prior authorization required if equipment is over $2,500 and for power-assisted wheelchairs, if not received, you will be responsible for the expense.
	Hospice services	20% co-insurance	40% co-insurance	No coverage for private duty nursing. Respite care limited to 5 consecutive days and 30 days lifetime.
If your child needs dental or eye care	Children's eye exam	$10 co-pay/visit, deductible does not apply	No charge, deductible does not apply, up to $40 then 100% co-insurance	For age 18 or younger, one routine eye exam/year.
	Children's glasses	No charge, deductible does not apply	No charge, deductible does not apply, up to $75 then 100% co-insurance	For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) per year.
	Children's dental check-up	Not covered	Not covered	Not covered

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
- Hearing aids (Adult)
- Non-emergency care when traveling outside the U.S.

- Cosmetic surgery (except in certain situations)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care, other than with diabetes mellitus

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

- Abortion
- Acupuncture
- Chiropractic care
- Hearing aids (Child)
- Routine eye care (Adult)
- Weight loss programs

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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: The PacificSource Customer Service team at 1-888-977-9299 or the Division of Financial Regulation at 1-888-877-4894 or at dfr.oregon.gov. For group health coverage subject to ERISA, you can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

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 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 1-888-977-9299.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-977-9299.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-977-9299.

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** $2,500
- **Specialist** 20% co-insurance
- **Hospital (facility)** 20% co-insurance
- **Other** 20% co-insurance

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	$2500
Copayments	$0
Coinsurance	$2000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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

- **The plan's overall deductible** $2,500
- **Specialist** 20% co-insurance
- **Hospital (facility)** 20% co-insurance
- **Other** 20% co-insurance

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	$2500
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,120**

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

- **The plan's overall deductible** $2,500
- **Specialist** 20% co-insurance
- **Hospital (facility)** 20% co-insurance
- **Other** 20% co-insurance

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	$2500
Copayments	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,560**

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