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, please contact the PacificSource customer service team at 1-888-246-1370. For 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 1-888-246-1370 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 individual/ $3,000 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, 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. Preventive care and Vision services are covered before you meet your deductible.	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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network provider: $2,000 individual/ $4,000 family | Out-of-network providers: $10,000 individual	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?	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 http://providerdirectory.PacificSource.com/?nPlan or call 1-888-246-1370 for a list of network providers. Please refer to your member id card for the name of your network.	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		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	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	Deductible then 10% coinsurance	Deductible then 20% coinsurance	None
	Specialist visit			
	Preventive care/screening/ immunization	No charge, deductible does not apply	20% coinsurance, deductible does not apply	Preventive Physicals: 13 visits ages 0-36 months, once per calendar year ages 3 and older. Well Woman Visits: once per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 10% coinsurance	Deductible then 20% coinsurance	None
	Imaging (CT/PET scans, MRIs)			Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **http://PacificSource.com/drug-list/PDL/.**	Tier one drugs	Retail and Mail: Deductible then 10% coinsurance	Deductible then 50% coinsurance or retail copay, whichever is greater.	Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge, deductible does not apply. Retail and Mail are limited to a 90 day supply. Preauthorization is required for certain drugs.
	Tier two drugs			
	Tier three drugs	Retail and Mail: Deductible then 25% coinsurance		
	Specialty drugs	Same as retail		In-network specialty drugs are limited to 30 day supply. Preauthorization is required for certain drugs. Out-of-network specialty drugs are limited to a 30-day supply, up to 3 fills per calendar year.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 10% coinsurance	Deductible then 20% coinsurance	None
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Medical Emergency: Deductible then 10% coinsurance Non-Emergency: Deductible then 10% coinsurance	Medical Emergency: Deductible then 10% coinsurance Non-Emergency: Deductible then 20% coinsurance	None
	Emergency medical transportation	Ground: Deductible then 10% coinsurance Air: Deductible then 10% coinsurance	Ground: Deductible then 10% coinsurance Air: Deductible then 10% coinsurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Out-of-network air based on 200 percent of Medicare allowance.
	Urgent care	Deductible then 10% coinsurance	Deductible then 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Preauthorization is required for some inpatient services.
	Physician/surgeon fees			None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible then 10% coinsurance	Deductible then 20% coinsurance	None
	Inpatient services			Preauthorization is required for some inpatient services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you are pregnant	Office visits	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Cost sharing does not apply to certain preventive services. Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services. Coverage includes termination of pregnancy.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	Deductible then 10% coinsurance	Deductible then 20% coinsurance	No coverage for private duty nursing or custodial care.
	Rehabilitation services	Inpatient: Deductible then 10% coinsurance Outpatient: Deductible then 10% coinsurance	Inpatient: Deductible then 20% coinsurance Outpatient: Deductible then 20% coinsurance	Inpatient: Covered. Preauthorization is required. Outpatient: Covered up to 60 visits/calendar year, unless medically necessary to treat a mental health diagnosis. Speech therapy is does not have a limit and does not accumulate to the 60 visits/calendar year. No coverage for recreation therapy.
	Habilitation services	Inpatient: Deductible then 10% coinsurance Outpatient: Deductible then 10% coinsurance	Inpatient: Deductible then 20% coinsurance Outpatient: Deductible then 20% coinsurance	Inpatient: Covered. Preauthorization is required. Outpatient: Covered up to 60 visits/calendar year, unless medically necessary to treat a mental health diagnosis. Speech therapy is does not have a limit and does not accumulate to the 60 visits/calendar year. No coverage for recreation therapy.
	Skilled nursing care	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Limited to 60 days/year. No coverage for custodial care. Preauthorization is required.
	Durable medical equipment			Limited to: one pair/year for glasses or contact lenses; one breast pump/pregnancy; $150/year for wig for chemotherapy or radiation therapy. Preauthorization is required if equipment is over $1,000 and for power-assisted wheelchairs.
	Hospice services			Preauthorization is required. No coverage for private duty nursing.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	No charge up to $40 maximum, then 100% coinsurance, deductible does not apply	One preventive eye exam/year for age 18 or younger.
	Children's glasses	No charge, deductible does not apply	No charge up to $75 maximum, then 100% coinsurance, deductible does not apply	For age 18 or younger, one pair of glasses (frames and lenses) or contact lenses in lieu of glasses per calendar year. Additional coatings not covered.
	Children's dental check-up	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
- Cosmetic surgery (except in certain situations)
- Custodial care
- Dental care (Adult)
- Dental check-up (Child)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 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: The PacificSource Customer Service team at 1-888-246-1370 or the Division of Financial Regulation at 1-888-877-4894 or at http://dfr.oregon.gov.

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 1-866-281-1464.

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	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,500
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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