



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?	\$200 individual/\$400 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 other services listed below with ' <u>deductible</u> 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?	\$1,600 individual/\$3,200 family /Prescription Drug OOP \$1,000 individual/\$2,000 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?	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, <u>deductible</u> does not apply. Subsequent visits, 10% <u>co-insurance</u> .	40% <u>co-insurance</u>	First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	<u>Specialist</u> visit	10% <u>co-insurance</u>	40% <u>co-insurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	40% <u>co-insurance</u> , <u>deductible</u> does not apply	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Tobacco cessation: Not covered out-of-network.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>co-insurance</u>	40% <u>co-insurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>co-insurance</u>	40% <u>co-insurance</u>	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 <u>prescription drug coverage</u> is available at PacificSource.com/drug-list	Generic drugs - Tier 1	Retail: \$5 <u>co-pay</u> , <u>deductible</u> does not apply Mail: \$10 <u>co-pay</u> , <u>deductible</u> does not apply	90% <u>co-insurance</u> , <u>deductible</u> does not apply	For all <u>prescription drug</u> list tiers: Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, <u>deductible</u> does not apply. <u>Cost share</u> 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 <u>Specialty drug</u> 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: \$10 <u>co-pay</u> , <u>deductible</u> does not apply Mail: \$20 <u>co-pay</u> , <u>deductible</u> does not apply	90% <u>co-insurance</u> , <u>deductible</u> does not apply	
	Non-preferred drugs - Tier 3	Retail: \$25 <u>co-pay</u> , <u>deductible</u> does not apply Mail: \$50 <u>co-pay</u> , <u>deductible</u> does not apply	90% <u>co-insurance</u> , <u>deductible</u> does not apply	

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
	Specialty drugs - Tier 4	Retail: The lesser of \$150 <u>co-pay</u> or 10% <u>co-insurance</u> , <u>deductible</u> does not apply Mail: The lesser of \$300 <u>co-pay</u> or 10% <u>co-insurance</u> , <u>deductible</u> does not apply	90% <u>co-insurance</u> , <u>deductible</u> does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>co-insurance</u>	40% <u>co-insurance</u>	Prior authorization required for some surgeries. If not received, you will be responsible for the expense.
	Physician/surgeon fees	10% <u>co-insurance</u>	40% <u>co-insurance</u>	None
If you need immediate medical attention	Emergency room care	Medical emergency: 10% <u>co-insurance</u> Non-emergency: 10% <u>co-insurance</u>	Medical emergency: 10% <u>co-insurance</u> Non-emergency: 10% <u>co-insurance</u>	None
	Emergency medical transportation	Ground: 30% <u>co-insurance</u> Air: 30% <u>co-insurance</u>	Ground: 30% <u>co-insurance</u> Air: 30% <u>co-insurance</u>	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	Urgent care	10% <u>co-insurance</u>	10% <u>co-insurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>co-insurance</u>	40% <u>co-insurance</u>	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	10% <u>co-insurance</u>	40% <u>co-insurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First three visits no charge, <u>deductible</u> does not apply. Subsequent visits, 10% <u>co-insurance</u> .	40% <u>co-insurance</u>	First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Inpatient services	10% <u>co-insurance</u>	40% <u>co-insurance</u>	Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.

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 are pregnant	Office visits	10% <u>co-insurance</u>	40% <u>co-insurance</u>	Cost sharing does not apply for <u>preventive services</u> . 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	10% <u>co-insurance</u>	40% <u>co-insurance</u>	
	Childbirth/delivery facility services	10% <u>co-insurance</u>	40% <u>co-insurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>co-insurance</u>	40% <u>co-insurance</u>	No coverage for private duty nursing or custodial care.
	<u>Rehabilitation services</u>	Inpatient: 10% <u>co-insurance</u> Outpatient: 10% <u>co-insurance</u>	Inpatient: 40% <u>co-insurance</u> Outpatient: 40% <u>co-insurance</u>	Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	<u>Habilitation services</u>	Inpatient: 10% <u>co-insurance</u> Outpatient: 10% <u>co-insurance</u>	Inpatient: 40% <u>co-insurance</u> Outpatient: 40% <u>co-insurance</u>	Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	<u>Skilled nursing care</u>	10% <u>co-insurance</u>	40% <u>co-insurance</u>	Limited to 60 days/year. No coverage for custodial care.
	<u>Durable medical equipment</u>	10% <u>co-insurance</u>	40% <u>co-insurance</u>	Limited to: 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.
	<u>Hospice services</u>	10% <u>co-insurance</u>	40% <u>co-insurance</u>	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 <u>co-pay/visit</u> , <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply, up to \$40 then 100% <u>co-insurance</u>	For age 18 or younger, one routine eye exam/year.
	Children's glasses	Lenses: \$10 <u>co-pay</u> , <u>deductible</u> does not apply Frames: No charge, <u>deductible</u> does not apply, up	Lenses: No charge, <u>deductible</u> does not apply, up to \$40 then 100% <u>co-insurance</u>	For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) per year.

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
		to \$150 then 100% <u>co-insurance</u> Contact lenses (in lieu of glasses): No charge, <u>deductible</u> does not apply, up to \$120 then 100% <u>co-insurance</u>	Frames: No charge, <u>deductible</u> does not apply, up to \$45 then 100% <u>co-insurance</u> Contact lenses (in lieu of glasses): No charge, <u>deductible</u> does not apply, up to \$105 then 100% <u>co-insurance</u>	
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery (except in certain situations) • Dental care (Adult) 	<ul style="list-style-type: none"> • Hearing aids (Adult) • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • Abortion • Acupuncture 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids (Child) 	<ul style="list-style-type: none"> • 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 cciio.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 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.

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** \$200
- **Specialist** 10% co-insurance
- **Hospital (facility)** 10% co-insurance
- **Other** 10% 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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,470

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$200
- **Specialist** 10% co-insurance
- **Hospital (facility)** 10% co-insurance
- **Other** 10% 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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
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** \$200
- **Specialist** 10% co-insurance
- **Hospital (facility)** 10% co-insurance
- **Other** 10% 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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$610

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