




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 <http://PacificSource.com/oregon/small-group-plan-details-2018>. 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 <http://www.dol.gov/ebsa/healthreform> or call 1-888-977-9299 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating provider: \$4,000 person/\$8,000 family Non-participating provider: \$7,500 person/\$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, 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. Participating: preventive care. Participating: preventive Rx drugs. Vision age 18 and younger - 1st \$150 vision hardware. Participating: vision exam. Non-participating: 1st \$40 vision exam.	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 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?	Participating provider: \$6,550 person/\$13,100 family Non-participating provider: \$11,250 person/\$22,500 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 http://providerdirectory.PacificSource.com/?nPPlan=Legacy+Health 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating 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	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	<u>Specialist</u> visit	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	<u>Deductible</u> then 50% <u>co-insurance</u> Tobacco Cessation: Not covered	Routine 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://PacificSource.com/drug-list/OR/ .	Tier one drugs	Retail: <u>Deductible</u> then 50% <u>co-insurance</u> Mail: <u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 90% <u>co-insurance</u>	Retail limited to 30 day supply. Mail limited to 90 day supply. <u>Preauthorization</u> required for certain drugs.
	Tier two drugs	Retail: <u>Deductible</u> then 50% <u>co-insurance</u> Mail: <u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 90% <u>co-insurance</u>	
	Tier three drugs	Retail: <u>Deductible</u> then 50% <u>co-insurance</u> Mail: <u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 90% <u>co-insurance</u>	
	Tier four <u>specialty</u> drugs	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 90% <u>co-insurance</u>	Participating <u>provider</u> benefit available only through our specialty pharmacy services <u>provider</u> . Limited to 30 day

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
				supply. <u>Preauthorization</u> required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	Physician/surgeon fees	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	
If you need immediate medical attention	Emergency room services	Medical Emergency: <u>Deductible</u> then 50% <u>co-insurance</u> Non-emergency: <u>Deductible</u> then 50% <u>co-insurance</u>	Medical Emergency: <u>Deductible</u> then 50% <u>co-insurance</u> Non-emergency: <u>Deductible</u> then 50% <u>co-insurance</u>	None
	<u>Emergency medical transportation</u>	Ground: <u>Deductible</u> then 50% <u>co-insurance</u> Air: <u>Deductible</u> then 50% <u>co-insurance</u>	Ground: <u>Deductible</u> then 50% <u>co-insurance</u> Air: <u>Deductible</u> then 50% <u>co-insurance</u>	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Non-participating air based on 200 percent of Medicare allowance.
	<u>Urgent care</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	Limited to semi-private room unless intensive or coronary care units, <u>medically necessary</u> isolation, or hospital only has private rooms. <u>Preauthorization</u> required for some inpatient services.
	Physician/surgeon fees	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	Inpatient services	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required for some inpatient services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
If you are pregnant	Office visits			<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . 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	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<u>Home health care</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	No coverage for private duty nursing or custodial care. <u>Preauthorization</u> required.
	<u>Rehabilitation services</u>	Inpatient: <u>Deductible</u> then 50% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 50% <u>co-insurance</u>	Inpatient: <u>Deductible</u> then 50% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required. No coverage for recreation therapy. Inpatient: Covered up to 30 days/year, unless <u>medically necessary</u> to treat a mental health diagnosis. Outpatient: Covered up to 30 visits/year, unless <u>medically necessary</u> to treat a mental health diagnosis.
	<u>Habilitation services</u>	Inpatient: <u>Deductible</u> then 50% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 50% <u>co-insurance</u>	Inpatient: <u>Deductible</u> then 50% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required. No coverage for recreation therapy. Inpatient: Covered up to 30 days/year, unless <u>medically necessary</u> to treat a mental health diagnosis. Outpatient: Covered up to 30 visits/year, unless <u>medically necessary</u> to treat a mental health diagnosis
	<u>Skilled nursing care</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	Limited to 60 days/year. No coverage for custodial care. <u>Preauthorization</u> required.
	<u>Durable medical equipment</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	Limited to: \$5,000/year overall; one pair/year for glasses or contact lenses; one/ear every 48 months for hearing aid; one breast pump/pregnancy; one wig/year for chemotherapy or radiation therapy. <u>Preauthorization</u> required if

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
				equipment is over \$1,000 and for power-assisted wheelchairs.
	<u>Hospice services</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required. No coverage for private duty nursing.
If your child needs dental or eye care	Children's eye exam	No charge, <u>deductible</u> does not apply	No charge up to \$40 maximum, <u>deductible</u> does not apply, then <u>Deductible</u> then 100% <u>co-insurance</u>	For age 18 or younger, one routine eye exam/year.
	Children's glasses	Combined participating and non-participating: No charge up to \$150 maximum, <u>deductible</u> does not apply, then subject to participating <u>providers</u> medical <u>deductible</u> and <u>co-insurance</u>	Combined participating and non-participating: No charge up to \$150 maximum, <u>deductible</u> does not apply, then subject to participating <u>providers</u> medical <u>deductible</u> and <u>co-insurance</u>	Combined participating and non-participating: For age 18 or younger, one pair of glasses (frames and lenses) or contact lenses in lieu of glasses per year. Additional coatings not covered.
	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
- Cosmetic surgery (except in certain situations)
- Custodial care
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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 (Adult)
- Hearing aids (Child)
- 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 www.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 <http://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 1-888-977-9299 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 www.dol.gov/ebsa/healthreform.

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 1-888-977-9299.

————— *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	\$4000
■ Specialist	50% <u>co-insurance</u>
■ Hospital (facility)	50% <u>co-insurance</u>
■ Other	50% <u>co-insurance</u>

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1720
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$4830
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,610

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$4000
■ Specialist	50% <u>co-insurance</u>
■ Hospital (facility)	50% <u>co-insurance</u>
■ Other	50% <u>co-insurance</u>

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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3234
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$3316
<u>What isn't covered</u>	
Limits or exclusions	\$55
The total Joe would pay is	\$6,605

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$4000
■ Specialist	50% <u>co-insurance</u>
■ Hospital (facility)	50% <u>co-insurance</u>
■ Other	50% <u>co-insurance</u>

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	\$1,925
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$963
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$963
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,926