



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/individual-plan-details-2019>. 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? | In-network <u>provider</u> : \$7,900 person/\$15,800 family Out-of-network <u>provider</u> : \$10,000 person/\$20,000 family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. In-network: <u>preventive care</u> ; 1st 3 office visits. In-network: preventive Rx drugs. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | In-network <u>provider</u> : \$7,900 person/\$15,800 family Out-of-network <u>provider</u> : \$25,000 person/\$50,000 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. See http://providerdirectory.PacificSource.com/?nPlan=SmartChoice or call 1-888-977-9299 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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 | No charge for first three visits, <u>deductible</u> does not apply, then <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | None |
| | <u>Specialist</u> visit | <u>Deductible</u> then No charge | <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 | 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. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | <u>Deductible</u> then No charge | <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 No charge Mail: <u>Deductible</u> then No charge | <u>Deductible</u> then 90% <u>co-insurance</u> | Retail and mail limited to 90 day supply. Specialty drugs limited to 30 day supply. <u>Preauthorization</u> required for certain drugs. |
| | Tier two drugs | Retail: <u>Deductible</u> then No charge Mail: <u>Deductible</u> then No charge | <u>Deductible</u> then 90% <u>co-insurance</u> | |
| | Tier three drugs | Retail: <u>Deductible</u> then No charge Mail: <u>Deductible</u> then No charge | <u>Deductible</u> then 90% <u>co-insurance</u> | |

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 |
|--|--|--|---|---|
| | Tier four drugs | <u>Deductible</u> then No charge | <u>Deductible</u> then 90% <u>co-insurance</u> | Retail and mail limited to 90 day supply. Specialty drugs limited to 30 day supply. <u>Preauthorization</u> required for certain drugs. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | None |
| | Physician/surgeon fees | <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | |
| If you need immediate medical attention | Emergency room services | Medical emergency: <u>Deductible</u> then No charge Non-emergency: <u>Deductible</u> then No charge | Medical emergency: <u>Deductible</u> then No charge Non-emergency: <u>Deductible</u> then 50% <u>co-insurance</u> | None |
| | <u>Emergency medical transportation</u> | Ground: <u>Deductible</u> then No charge Air: <u>Deductible</u> then No charge | Ground: <u>Deductible</u> then No charge Air: <u>Deductible</u> then No charge | 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. |
| | <u>Urgent care</u> | <u>Deductible</u> then No charge | <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 No charge | <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 No charge | <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 No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | None |
| | Inpatient services | <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | <u>Preauthorization</u> required for some inpatient services. |

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 | | | <p><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.</p> |
| | Childbirth/delivery professional services | <u>Deductible</u> then No charge | <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 No charge | <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 No charge Outpatient: <u>Deductible</u> then No charge | Inpatient: <u>Deductible</u> then 50% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 50% <u>co-insurance</u> | Inpatient: Covered up to 30 days/year, unless <u>medically necessary</u> to treat a mental health diagnosis. <u>Preauthorization</u> required. Outpatient: Covered up to 30 visits/year unless <u>medically necessary</u> to treat a mental health diagnosis. No coverage for recreation therapy. |
| | <u>Habilitation services</u> | Inpatient: <u>Deductible</u> then No charge Outpatient: <u>Deductible</u> then No charge | Inpatient: <u>Deductible</u> then 50% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 50% <u>co-insurance</u> | Inpatient: Covered up to 30 days/year, unless <u>medically necessary</u> to treat a mental health diagnosis. <u>Preauthorization</u> required. Outpatient: Covered up to 30 visits/year unless <u>medically necessary</u> to treat a mental health diagnosis. No coverage for recreation therapy. |
| | <u>Skilled nursing care</u> | <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | Limited to 60 days/year. No coverage for custodial care. |

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 |
|---|----------------------------------|--|---|--|
| | <u>Durable medical equipment</u> | <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | Limited to: \$5,000/year overall; one pair/year for glasses or contact lenses; one breast pump/pregnancy; one wig/year for chemotherapy or radiation therapy. <u>Preauthorization</u> required if equipment is over \$1000 and for power-assisted wheelchairs. |
| | <u>Hospice services</u> | <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | No coverage for private duty nursing. |
| If your child needs dental or eye care | Children's eye exam | <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | For age 18 or younger, one routine eye exam/year. |
| | Children's glasses | <u>Deductible</u> then No charge | <u>Deductible</u> then 50% <u>co-insurance</u> | Combined in-network and out-of-network: For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- 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
- 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: Division of Financial Regulation at 1-888-877-4894 or at <http://dfr.oregon.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 <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 <http://dfr.oregon.gov>.

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** \$7,900
- **Specialist** 0% co-insurance
- **Hospital (facility)** 0% co-insurance
- **Other** 0% 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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

Cost Sharing

| | |
|--------------------|--------|
| <u>Deductibles</u> | \$7900 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$7,960 |
|-----------------------------------|----------------|

Managing Joe's type 2 Diabetes

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

- **The plan's overall deductible** \$7,900
- **Specialist** 0% co-insurance
- **Hospital (facility)** 0% co-insurance
- **Other** 0% 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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

Cost Sharing

| | |
|--------------------|--------|
| <u>Deductibles</u> | \$7184 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$55 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$7,239 |
|-----------------------------------|----------------|

Mia's Simple Fracture

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

- **The plan's overall deductible** \$7,900
- **Specialist** 0% co-insurance
- **Hospital (facility)** 0% co-insurance
- **Other** 0% 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 | \$1,925 |
|---------------------------|----------------|

In this example, Mia would pay:

Cost Sharing

| | |
|--------------------|--------|
| <u>Deductibles</u> | \$1925 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$1,925 |
|-----------------------------------|----------------|