**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 https://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 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: $8,550 individual/$17,100 family \| Out-of-network provider: $10,000 individual/$20,000 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. In-network: preventive care; office visits; outpatient rehab in an office setting. In-network: Tier one Rx drugs. Vision age 18 and younger - 1st $150 vision hardware. In-network: vision exam. Out-of-network: 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 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: $8,550 individual/$17,100 family \| Out-of-network provider: $25,000 individual/$50,000 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/?nPlan=SmartChoice 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 | $50 co-pay/visit, deductible does not apply | 50% co-insurance | None |
| | Specialist visit | $100 co-pay/visit, deductible does not apply | 50% co-insurance | None |
| | Preventive care/screening/immunization | No charge, deductible does not apply | 50% 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) | No charge | 50% co-insurance | None |
| | Imaging (CT/PET scans, MRIs) | No charge | 50% co-insurance | Preauthorization required. |
| | Tier one drugs | Retail: $20 co-pay/prescription, deductible does not apply<br>Mail: $40 co-pay/prescription, deductible does not apply | 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 need drugs to treat your illness or condition** More information about prescription drug coverage is available at https://pacificsource.com/drug-list | Tier two drugs | Retail: No charge<br>Mail: No charge | 90% co-insurance | 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. Preauthorization required for certain drugs. If a manufacturer coupon or rebate is used, the amount of the discount will not accumulate toward the deductible or the maximum out-of-pocket limit. |
| | Tier three drugs | Retail: No charge<br>Mail: No charge | 90% co-insurance | |
| | Tier four drugs | No charge | 90% co-insurance | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 50% co-insurance | None |
| | Physician/surgeon fees | No charge | 50% co-insurance | |
| **If you need immediate medical attention** | Emergency room care | Medical emergency: No charge<br>Non-emergency: No charge | Medical emergency: No charge<br>Non-emergency: 50% co-insurance | None |
| | Emergency medical transportation | Ground: No charge<br>Air: No charge | Ground: No charge<br>Air: 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. |
| | Urgent care | $100 co-pay/visit, deductible does not apply | 50% co-insurance | None |

| 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 a hospital stay** | Facility fee (e.g., hospital room) | No charge | 50% co-insurance | Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Preauthorization required for some inpatient services. |
| | Physician/surgeon fees | No charge | 50% co-insurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $50 co-pay/visit, deductible does not apply | 50% co-insurance | None |
| | Inpatient services | No charge | 50% co-insurance | Preauthorization required for some inpatient services. |
| **If you are pregnant** | Office visits | No charge | 50% co-insurance | Cost sharing does not apply for 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 | | | |
| | Home health care | No charge | 50% co-insurance | No coverage for private duty nursing or custodial care. Preauthorization required. |

| 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** | Rehabilitation services | Inpatient: No charge<br>Outpatient: $50 co-pay/visit, deductible does not apply, if provided in an office setting, all other settings No charge | Inpatient: 50% co-insurance<br>Outpatient: 50% co-insurance | Inpatient: Covered up to 30 days/year, unless medically necessary to treat a mental health diagnosis. Preauthorization required.<br>Outpatient: Covered up to 30 visits/year unless medically necessary to treat a mental health diagnosis.<br>No coverage for recreation therapy. |
| | Habilitation services | Inpatient: No charge<br>Outpatient: $50 co-pay/visit, deductible does not apply, if provided in an office setting, all other settings No charge | Inpatient: 50% co-insurance<br>Outpatient: 50% co-insurance | Inpatient: Covered up to 30 days/year, unless medically necessary to treat a mental health diagnosis. Preauthorization required.<br>Outpatient: Covered up to 30 visits/year unless medically necessary to treat a mental health diagnosis.<br>No coverage for recreation therapy. |
| | Skilled nursing care | No charge | 50% co-insurance | Limited to 60 days/year. No coverage for custodial care. |
| | Durable medical equipment | No charge | 50% co-insurance | 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. Preauthorization required if equipment is over $1,000 and for power-assisted wheelchairs. |
| | Hospice services | No charge | 50% co-insurance | No coverage for private duty nursing. |

| 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 your child needs dental or eye care** | Children's eye exam | No charge, deductible does not apply | No charge up to $40 maximum, deductible does not apply, then 100% co-insurance | For age 18 or younger, one routine eye exam/year. |
| | Children's glasses | Combined in-network and out-of-network: No charge | Combined in-network and out-of-network: No charge | 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. No charge up to $150 maximum, deductible does not apply. |
| | 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)
- Dental care (Adult)
- 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 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 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? Not Applicable.**
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** $8,550
- **Specialist** $100 co-payment
- **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** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $8550 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$8,610** |

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

- **The plan's overall deductible** $8,550
- **Specialist** $100 co-payment
- **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** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $4000 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$4,720** |

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

- **The plan's overall deductible** $8,550
- **Specialist** $100 co-payment
- **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** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2100 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,600** |

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