This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at PacificSource.com or by calling 1-888-977-9299

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating provider: $750 person/$1875 family, Non-participating provider: $1500 person/$3750 family Doesn't apply to Participating provider: preventive care, alt/chiro, office visits, vision exam and hardware, and emergency room visits. Non-participating provider: vision exam and hardware, and emergency room visits. Rx drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $3250 person participating provider/$6875 family participating provider | $5250 person non-participating provider/$11250 family non-participating provider.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see PacificSource.com or call **1-888-977-9299**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	40% co-insurance	---none---
	Specialist visit	$25 co-pay/visit	40% co-insurance	---none---
	Other practitioner office visit	20% co-insurance	20% co-insurance	Acupuncture and massage therapy limited to a combined benefit of 24 visits/year. Chiropractic care limited to a benefit of 24 visits/year. medicines, and supplies
	Preventive care/screening/immunization	No charge	Well baby, Routine Physicals, Mammograms, Tobacco Cessation and Immunizations: 90% co-insurance Well Woman and Routing Colonoscopy: 40% co-insurance	Limited to: Routine Physicals: 13 visits ages 0-36 months, one exam every 12 months ages 3-21, one exam every 48 months ages 22-34, one exam every 24 months ages 35-59, and one exam every 12 months age 60+. Well Woman Visits: annually. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended. Preventive Colonoscopy: Ages 50-75. High Risk Colonoscopy: Under age 50.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	---none---

	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at PacificSource.com.	Generic drugs	Retail: $15 co-pay Mail: $15 co-pay	Same as the retail pharmacy	Retail limited to 34-day supply. Mail limited to 90-day supply. Pre-authorization required for certain drugs. There is an RX out-of-pocket limit of $750 per year. Once the out-of-pocket limit is reached, co-pays for drugs obtained from a participating pharmacy are waived for the remainder of the year. Differential between generic and brand drugs, and non-participating pharmacy charges do not apply to the RX out-of-pocket limit.
	Preferred brand drugs	Retail: $30 co-pay Mail: $60 co-pay	Same as the retail pharmacy	See Generic drugs above.
	Non-preferred brand drugs	Retail: $50 co-pay Mail: $100 co-pay	Same as the retail pharmacy	See Generic drugs above.
	Specialty drugs	Same as the mail order pharmacy	Same as the mail order pharmacy	Coverage available only through our specialty pharmacy services provider. Limited to 30-day supply. Pre-authorization required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	---none---
	Physician/surgeon fees	20% co-insurance	40% co-insurance	---none---
If you need immediate medical attention	Emergency room services	$100 co-pay/visit plus 20% co-insurance	$100 co-pay/visit plus 40% co-insurance	Co-pay waived if admitted. Non-participating paid as participating if emergency medical condition.
	Emergency medical transportation	Ground: 20% co-insurance Air: 20% co-insurance	Ground: 20% co-insurance Air: 20% co-insurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Non-participating air covered up to 125% of the Medicare allowance.
	Urgent care	$25 co-pay/visit	40% co-insurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Limited to semi-private room unless intensive or coronary care units,

				medically necessary isolation, or hospital only has private rooms. Pre-authorization required for some inpatient services.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/visit	40% co-insurance	---none---
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Pre-authorization required.
	Substance use disorder outpatient services	$25 co-pay/visit	40% co-insurance	---none---
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Pre-authorization required.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	Preventive prenatal: No co-insurance.
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	50% co-insurance	Limited to 180 days/year. No coverage for private duty nursing or custodial care. Pre-authorization required.
	Rehabilitation services	Inpatient: 20% co-insurance Outpatient: 20% co-insurance	Inpatient: 40% co-insurance Outpatient: 30% co-insurance	Inpatient: Limited to 30 days/year; 60 days if head or spinal cord injury. Pre-authorization required. Outpatient: Limited to 30 visits/year up to 30 additional visits if neurological condition. No coverage for recreation therapy.
	Habilitation services	Inpatient: 20% co-insurance Outpatient: 20% co-insurance	Inpatient: 40% co-insurance Outpatient: 30% co-insurance	Inpatient: Limited to 30 days/year; 60 days if head or spinal cord injury. Pre-authorization required. Outpatient: Limited to 30 visits/year up to 30 additional visits if neurological condition. No coverage for recreation

				therapy.
	Skilled nursing care	20% co-insurance	40% co-insurance	Limited to 100 days/year. No coverage for custodial care. Pre-authorization required.
	Durable medical equipment	20% co-insurance	40% co-insurance	Limited to: pre-authorization for power-assisted wheelchairs; one pair/year for glasses or contact lenses to correct a specific vision defect from a severe medical or surgical problem; one hearing aid per ear every 48 months age 0-18 (or age 0-25 if student); $800 per 36 months for age 18+; one breast pump/pregnancy; and $150/year for wig for chemotherapy or radiation therapy. Pre-authorization required if over $800.
	Hospice service	20% co-insurance	50% co-insurance	Limited to $8,000. Respite care limited to 120 hours every 3 months when arranged by the attending physician. Pre-authorization required. No coverage for private duty nursing.
If your child needs dental or eye care	Eye exam	No charge	No charge	One routine eye exam per calendar year for children 18 or younger when provided by a licensed ophthalmologist or optometrist. Non-participating benefit further limited to $64.50 every 12 months
	Glasses	No charge	No charge	One pair of non-collection glasses (lenses and frames) per calendar year for children 18 or younger or contact lenses with certain limitations. Preauthorization required for purchases over $175. Additional coatings not covered.
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Custodial Care
- Dental Care (Adult)
- Dental Check-up(Child)
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Outpatient Recreational Therapy
- Private Duty Nursing
- Routine foot care, other than with diabetes mellitus

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic Care
- Hearing aids (Adult)
- Hearing aids (Child)
- Infertility Treatment
- Routine eye care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-888-977-9299. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the PacificSource Customer Service Department at 1-888-977-9299. 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. Additional, a consumer assistance program can help you file your appeal. Contact the Oregon Insurance Division's Consumer Advocacy Unit at 1-503-947-7984 or toll-free at 1-888-877-4894.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,200
- **Patient pays** $1,340

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$750
Co-pays	$20
Co-insurance	$420
Limits or exclusions	$150
Total	$1,340

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,560
- **Patient pays** $1,840

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$750
Co-pays	$790
Co-insurance	$220
Limits or exclusions	$80
Total	$1,840

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact; 1-888-977-9299.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, co-payments,** and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments, deductibles,** and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.