



**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:
<b>What is the overall <u>deductible</u>?</b>	\$1500 person / \$3000 family Doesn't apply to preventative care from participating providers and eye exams from participating and non-participating providers.	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> 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 <b><u>deductible</u></b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. \$3000 person \$6000 family	The <b><u>out-of-pocket limit</u></b> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balanced-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes. For a list of <b><u>preferred providers</u></b> , see PacificSource.com or call 1-888-977-9299	If you use an in-network doctor or other health care <b><u>provider</u></b> , 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 <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their network. See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No.	You can see the <b><u>specialist</u></b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	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 <b><u>excluded services</u></b> .

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- **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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	40% co-insurance	---none---
	Specialist visit	20% co-insurance	40% co-insurance	---none---
	Other practitioner office visit			
	Acupuncture	20% co-insurance	40% co-insurance	Acupuncture limited to a combined \$500/year.
	Naturopath	20% co-insurance	40% co-insurance	Naturopath limited to a combined \$500/year.
	Chiropractic Care	20% co-insurance	40% co-insurance	Chiropractic care limited to a combined \$500/year. No coverage for drugs, homeopathic medicines or supplies, and maternity.
	Massage Therapy	Not covered	Not covered	No coverage for Massage Therapy.
	Preventive care/screening/immunization			Limited to: Routine Physicals: 13 visits ages 0-36 months, annually ages 3-21, 1 per 4 years ages 22-34, 1 per 2 years ages 35-59, and annually age 60+. Well Woman Visits: annually. Tobacco Cessation: 2 quit attempts in lifetime. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended.
	Routine Physicals	No charge	40% co-insurance	
	Well Baby/Child Visit	No charge	40% co-insurance	
Well Woman Visit	No charge	40% co-insurance		
Tobacco Cessation	No charge	Not covered		
Immunizations	No charge	40% co-insurance		
Preventive Colonoscopy	No charge	40% co-insurance		
If you have a test	Diagnostic test (x-ray, blood work)			---none---
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
		20% co-insurance	40% co-insurance	Pre-authorization required; no coverage if not pre-authorized.
<b>If you need drugs to treat your illness or condition</b>  <b>More information about <u>prescription drug coverage</u> is available at <a href="http://PacificSource.com">PacificSource.com</a></b>	Generic drugs	Retail: 20% co-insurance Mail: 20% co-insurance	Retail: 50% co-insurance Mail: 50% co-insurance	Retail limited to 30-day supply. Mail limited to 90-day supply. Pre-authorization required for certain drugs.
	Preferred brand drugs	Retail: 20% co-insurance Mail: 20% co-insurance	Retail: 50% co-insurance Mail: 50% co-insurance	See Generic drugs above
	Non-preferred brand drugs	Retail: 20% co-insurance Mail: 20% co-insurance	Retail: 50% co-insurance Mail: 50% co-insurance	See Generic drugs above
	Specialty drugs	20% co-insurance	50% co-insurance	Coverage available only through our specialty pharmacy services provider. Limited to 30-day supply. Pre-authorization required for certain drugs.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	---none---
	Physician/surgeon fees	20% co-insurance	40% co-insurance	---none---
<b>If you need immediate medical attention</b>	Emergency room services	20% co-insurance	40% co-insurance	Non-participating paid as participating if emergency medical condition.
	Emergency medical transportation Ground Ambulance Air Ambulance	20% co-insurance 20% co-insurance	20% co-insurance 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 Medicare allowance.
	Urgent care	20% co-insurance	40% co-insurance	---none---
<b>If you have a hospital stay</b>	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

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		Participating Provider	Non-Participating Provider		
	Physician/surgeon fee	20% co-insurance	40% co-insurance	private rooms. Pre-authorization required for inpatient elective surgery. ---none---	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	---none---	
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Small Employer Group: Long-term residential programs limited to 45 days/year. ---none---	
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	---none---	
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Small Employer Group: Long-term residential programs limited to 45 days/year.	
<b>If you are pregnant</b>	Prenatal and postnatal care	20% co-insurance	40% co-insurance	---none---	
	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.	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% co-insurance	40% co-insurance	No coverage for private duty nursing. Pre-authorization required.	
	Rehabilitation services:	Inpatient	20% co-insurance	40% co-insurance	Inpatient: Limited to 30 days/condition; 60 days if head or spinal cord injury.
		Outpatient	20% co-insurance	40% co-insurance	Outpatient: Limited to 30 visits/year; up to 30 additional visits if neurological condition. Subject to pre-authorization and criteria. No coverage for recreation therapy.
	Habilitation services:	Inpatient	20% co-insurance	40% co-insurance	Inpatient: Limited to 30 days/condition; 60 days if head or spinal cord injury.
Outpatient		20% co-insurance	40% co-insurance	Outpatient: Limited to 30 visits/year; up to 30 additional visits if neurological condition. Subject to pre-authorization and criteria. No coverage for recreation therapy.	

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Skilled nursing care	20% co-insurance	40% co-insurance	Limited to 14 days/stay. No coverage for custodial care. Pre-authorization required to authorized up to 100 additional days.
	Durable medical equipment	20% co-insurance	40% co-insurance	Limited to: One/lifetime age 19+ for power-assisted wheelchairs; \$200 for glasses or contact lenses to correct a specific vision defect from a severe medical or surgical problem; \$4,000 per 48 months for hearing aid age 0-18 (or age 0-25 if student); no coverage for adult hearing aids; and \$150/year for wig for chemotherapy or radiation therapy. Preauthorization required if over \$800.
	Hospice service	20% co-insurance	40% co-insurance	Preauthorization required for inpatient hospice. No coverage for private duty nursing.
<b>If your child needs dental or eye care</b>	Eye Exam	\$15 co-pay visit	30% co-insurance	Once every 12 months age 18 and under; once every 24 months age 19 and over.
	Glasses	Not covered	Not covered	Not covered
	Dental Check-up	Not Covered	Not Covered	Not Covered

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**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)
- Glasses ( Child)
- Hearing Aids (Adult)
- Infertility Treatment
- Long Term Care
- Massage Therapy
- Non-emergency care when traveling outside the US
- 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 (Child)
- 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](http://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](http://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](http://www.dol.gov/ebsa/healthreform). Additionally, 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.

**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.*

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## 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:	\$7540
■ Plan pays	\$4810
■ Patient pays	\$2730

#### Sample care costs:

Hospital charges (mother)	\$2700
Routine obstetric care	\$2100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7540</b>

#### Patient pays:

Deductibles	\$1500
Co-pays	\$0
Co-insurance	\$1200
Limits or exclusions	\$30
<b>Total</b>	<b>\$2730</b>

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

■ Amount owed to providers:	\$5400
■ Plan pays:	\$3060
■ Patient pays:	\$2340

#### Sample care costs:

Prescriptions	\$2900
Medical Equipment and Supplies	\$1300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5400</b>

#### Patient pays:

Deductibles	\$1500
Co-pays	\$0
Co-insurance	\$800
Limits or exclusions	\$40
<b>Total</b>	<b>\$2340</b>

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.

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## 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.

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