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/oregon/large-group-plan-details-2016 or by calling 1-888-977-9299.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating provider: $750 person/$1,875 family | Non-participating provider: $1,500 person/$3,750 family Doesn't apply to vision exam and hardware and Participating provider: preventive care, office visits, chiropractic manipulations, acupuncture, massage therapy, 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 $3,250 person participating provider/$6,875 family participating provider | $5,250 person non-participating provider/$11,250 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 services this plan doesn't cover are listed under the **Excluded Services & Other Covered Services** of this SBC. See your policy or plan document for additional information about **excluded services**.

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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 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	Deductible then 40% co-insurance	---none---
	Specialist visit	$25 co-pay/visit	Deductible then 40% co-insurance	---none---
	Other practitioner office visit	$25 co-pay/visit	Deductible then 40% co-insurance	Chiropractic manipulations, acupuncture, and massage therapy limited to a combined $2,500/year. No coverage for drugs, homeopathic medicines and supplies.
	Preventive care/screening/immunization	No charge	Deductible then 90% co-insurance Well Woman and Routine Colonoscopy: Deductible then 40% co-insurance Tobacco Cessation: Not covered	Limited to: Routine Physicals: 13 visits ages 0-36 months, annually ages 3 and older. 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)	Deductible then 20% co-insurance	Deductible then 40% co-insurance	---none---

	Imaging (CT/PET scans, MRIs)	Deductible then 20% co-insurance	Deductible then 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	Preventive drugs: No charge Retail: $15 co-pay Mail: $15 co-pay	Same as retail	Retail limited to 34-day supply. Mail limited to 90-day supply. Pre-authorization required for certain drugs.
	Preferred brand drugs	Retail: $30 co-pay Mail: $60 co-pay	Same as retail	See Generic drugs above.
	Non-preferred brand drugs	Retail: $50 co-pay Mail: $100 co-pay	Same as retail	See Generic drugs above.
	Specialty drugs	Same as mail order	Same as mail order	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)	Deductible then 20% co-insurance	Deductible then 40% co-insurance	---none---
	Physician/surgeon fees	Deductible then 20% co-insurance	Deductible then 40% co-insurance	---none---
If you need immediate medical attention	Emergency room services	Medical Emergency: $100 co-pay/visit plus 20% co-insurance Non-Emergency: $100 co-pay/visit plus 20% co-insurance	Medical Emergency: $100 co-pay/visit plus 20% co-insurance Non-Emergency: $100 co-pay/visit plus 40% co-insurance	Co-pay waived if admitted.
	Emergency medical transportation	Ground: Deductible then 20% co-insurance Air: Deductible then 20% co-insurance	Ground: Deductible then 20% co-insurance Air: Deductible then 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 200% of Medicare allowance.
	Urgent care	$25 co-pay/visit	Deductible then 40% co-insurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% co-insurance	Deductible then 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	Deductible then 20% co-insurance	Deductible then 40% co-insurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/visit	Deductible then 40% co-insurance	---none---
	Mental/Behavioral health inpatient services	Deductible then 20% co-insurance	Deductible then 40% co-insurance	Pre-authorization required.
	Substance use disorder outpatient services	$25 co-pay/visit	Deductible then 40% co-insurance	---none---
	Substance use disorder inpatient services	Deductible then 20% co-insurance	Deductible then 40% co-insurance	Pre-authorization required.
If you are pregnant	Prenatal and postnatal care	Deductible then 20% co-insurance	Deductible then 40% co-insurance	Preventive prenatal: No co-insurance.
	Delivery and all inpatient services	Deductible then 20% co-insurance	Deductible then 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. Coverage includes termination of pregnancy.
If you need help recovering or have other special health needs	Home health care	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Limited to 180 days/year. No coverage for private duty nursing or custodial care. Pre-authorization required.
	Rehabilitation services	Inpatient: Deductible then 20% co-insurance Outpatient: Deductible then 20% co-insurance	Inpatient: Deductible then 40% co-insurance Outpatient: Deductible then 40% co-insurance	Inpatient: Covered up to a combined 30 days/year, unless medically necessary to treat a mental health diagnosis. Pre-authorization required. Outpatient: Covered up to 30 visits/year, unless medically necessary to treat a mental health diagnosis. Pre-authorization required. No coverage for recreation therapy.
	Habilitation services	Inpatient: Deductible then 20% co-insurance Outpatient:	Inpatient: Deductible then 40% co-insurance Outpatient:	Inpatient: Covered up to a combined 30 days/year, unless medically necessary to treat a mental health diagnosis. Pre-authorization required.

		Deductible then 20% co-insurance	Deductible then 40% co-insurance	Outpatient: Covered up to 30 visits/year, unless medically necessary to treat a mental health diagnosis. Pre-authorization required. No coverage for recreation therapy.
	Skilled nursing care	Deductible then 20% co-insurance	Deductible then 40% co-insurance	Limited to 100 days/year. No coverage for custodial care. Pre-authorization required.
	Durable medical equipment	Deductible then 20% co-insurance	Deductible then 40% co-insurance	Limited to: Pre-authorization required 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 per ear every 48 months for hearing aid age 0-18 (or age 0-25 if student); $800 per 36 months for age 18+ for adult hearing aids; and one breast pump/pregnancy. Pre-authorization required if over $800.
	Hospice service	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Pre-authorization required. No coverage for private duty nursing.
If your child needs dental or eye care	Eye exam	No charge	No charge up to $64.50	One routine eye exam per calendar year for children 18 or younger when provided by a licensed ophthalmologist or optometrist.
	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. 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
- Massage Therapy
- 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 by calling (503) 947-7984 or the toll free message line at (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883; through the Internet at http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx; or by e-mail at: cp.ins@state.or.us, or 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** $5,320
- **Patient pays** $2,220

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	$1,300
Limits or exclusions	$150
Total	**$2,220**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,600
- **Patient pays** $1,800

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	$750
Co-insurance	$220
Limits or exclusions	$80
Total	**$1,800**

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.