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, please contact the PacificSource customer service team at 1-888-246-1370. 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 at Healthcare.gov/sbc-glossary/ or call 1-888-246-1370 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 - Deschutes County Onsite Clinic provider: $0 | Tier 2 - Navigator in-network provider and out-of-network providers: $2,500 individual/ $5,000 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. Preventive care and other services listed below with 'deductible does not apply'.	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?	Medical: Tier 1 - Deschutes County Onsite Clinic provider: $0 | Tier 2 - Navigator in-network provider: $5,000 individual/ $10,000 family | Out-of-network providers: $10,000 individual/ $20,000 family | Prescription drugs: $1,200 individual / $3,200 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 or call 1-888-246-1370 for a list of network providers. Please refer to your member id card for the name of your network.	You pay the least if you use a provider in Tier 1. You will pay more if you use a provider in Tier 2. 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - Deschutes County Onsite Clinic Provider (You will pay the least)	Tier 2 - Navigator In-network Provider (You will pay more)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge, deductible does not apply	First 3 visits $5 copayment/visit, deductible does not apply. Subsequent visit, $25 copayment/visit, deductible does not apply	$25 copayment/visit plus 20% coinsurance, deductible does not apply	First 3 visits/benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Specialist visit				
	Preventive care/screening/ immunization	No charge, deductible does not apply		20% coinsurance, deductible does not apply	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. Tier 1 Deschutes County Onsite Clinic Provider – The following are not available: Well baby/well child care, mammograms, colonoscopy, prostate cancer screening, and electron beam tomography (EBT).
If you have a test	Diagnostic test (x-ray, blood work)	No charge, deductible does not apply	20% coinsurance, deductible does not apply	40% coinsurance, deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	Not available			Prior authorization required. If not received, you will be responsible for the expense.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - Deschutes County Onsite Clinic Provider (You will pay the least)	Tier 2 - Navigator In-network Provider (You will pay more)	Out-of-network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Deschutes County Onsite Clinic: (541) 385-1071. http://www.deschutes.org/benefits/page/doc-pharmacy Prescryptive Health: (206) 686-9016. Walmart Home Delivery: (800) 273-3455. www.WALMART.COM/HOMEDELIVERY	Generic drugs - Tier 1	Deschutes County Onsite Clinic: 30 day supply: $2 copayment/prescription, deductible does not apply. 90 day supply: $4 copayment/prescription, deductible does not apply	Prescryptive Health: 34 day supply: $20 copayment/prescription, deductible does not apply. Walmart Home Delivery Mail 100 day supply / Retail 90 day supply: $40 copayment/prescription, deductible does not apply	50% coinsurance, deductible does not apply	Deschutes County Onsite Clinic Retail is limited to a 90 day supply. Prescryptive Health Retail is limited to a 34 day supply. Walmart Home Deliver Retail is limited to a 90 day supply, Mail Order is limited to a 100 day supply. Out-of-network is limited to a 34 day supply at retail. In-network formulary prescription insulin is not subject to a deductible and may not exceed $85 per 30 day supply or $255 for a 90 day supply. Prior authorization is required for certain drugs. If not received, you will be responsible for the expense.
	Formulary drugs	Deschutes County Onsite Clinic: 30 day supply: $20 copayment/prescription, deductible does not apply 90 day supply: $40 copayment/prescription, deductible does not apply	Prescryptive Health: 34 day supply: Greater of 20% coinsurance or $50 copayment/prescription up to a maximum of $100, deductible does not apply. Walmart Home Delivery Mail 100 day supply / Retail 90 day supply: Greater of 20% coinsurance or $100 copayment/prescription up to a maximum of $200, deductible does not apply.		
	Non-formulary drugs	Deschutes County Onsite Clinic: 30 day supply: $40 copayment/prescription, deductible does not apply 90 day supply: $80 copayment/prescription, deductible does not apply	Prescryptive Health: 34 day supply: Greater of 20% coinsurance or $75 copayment/prescription up to a maximum of $125, deductible does not apply. Walmart Home Delivery Mail 100 day supply / Retail 90 day supply: Greater of 20% coinsurance or $150 copayment/prescription		

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - Deschutes County Onsite Clinic Provider (You will pay the least)	Tier 2 - Navigator In-network Provider (You will pay more)	Out-of-network Provider (You will pay the most)	
			up to a maximum of $300, deductible does not apply.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not available	20% coinsurance	40% coinsurance	Prior authorization required for some surgeries. If not received, you will be responsible for the expense.
	Physician/ surgeon fees				None
If you need immediate medical attention	Emergency room care	Not available	$100 copayment/admit, 20% coinsurance		Copayment waived if admitted. Non-emergency care is not covered in the emergency room.
	Emergency medical transportation		20% coinsurance		Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	Urgent care	No charge, deductible does not apply	$25 copayment/visit, deductible does not apply	$25 copayment/visit plus 20% coinsurance, deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not available	$100 copayment /admit, 20% coinsurance	$100 copayment /admit, 40% coinsurance	Limited to semi-private room, except when a private room is determined to be necessary. Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.
	Physician/ surgeon fees		20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge, deductible does not apply	First 3 visits $5 copayment/visit, deductible does not apply. Subsequent visit, $25 copayment/visit, deductible does not apply	$25 copayment/visit plus 20% coinsurance, deductible does not apply	First 3 visits/benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Inpatient services	Not available	20% coinsurance	40% coinsurance	Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - Deschutes County Onsite Clinic Provider (You will pay the least)	Tier 2 - Navigator In-network Provider (You will pay more)	Out-of-network Provider (You will pay the most)	
If you are pregnant	Office visits	Not available	12% coinsurance, deductible does not apply	40% coinsurance	Cost sharing does not apply to certain preventive services. Delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services.
	Childbirth/delivery professional services				
	Childbirth/delivery facility services		20% coinsurance		
If you need help recovering or have other special health needs	Home health care	Not available	20% coinsurance	40% coinsurance	Limited to 180 visits/benefit year. No coverage for private duty nursing or custodial care.
	Rehabilitation services		Inpatient: 20% coinsurance Outpatient: $10 copayment /visit		Inpatient: Limited to 30 days/benefit year. Outpatient: Limited to 30 visits/ benefit year. Up to 30 additional visits will be allowed for head and spinal injury, cardiovascular accident, stroke, or major injury. No coverage for recreation therapy.
	Habilitation services				Inpatient: Limited to 30 days/benefit year. Outpatient: Limited to 30 visits/ benefit year. Up to 30 additional visits will be allowed for head and spinal injury, cardiovascular accident, stroke, or major injury. No coverage for recreation therapy.
	Skilled nursing care				No coverage for custodial care.
	Durable medical equipment		20% coinsurance		Limited to: one pair/benefit year for glasses or contact lenses; one breast pump/pregnancy; $150/ benefit year for wig for chemotherapy or radiation therapy. Prior authorization is required if equipment is over $2,500 and for power-assisted wheelchairs. If not

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 - Deschutes County Onsite Clinic Provider (You will pay the least)	Tier 2 - Navigator In-network Provider (You will pay more)	Out-of-network Provider (You will pay the most)	
					received, you will be responsible for the expense.
	Hospice services	Not available	20% coinsurance	40% coinsurance	No coverage for private duty nursing. Respite care limited to 5 consecutive days and 30 days/lifetime.
If your child needs dental or eye care	Children's eye exam	Not available	No charge, deductible does not apply		For age 18 or younger, one preventive eye exam/benefit year, includes contact fitting if applicable.
	Children's glasses		No charge, deductible does not apply up to $250.		Combined in-network and out-of-network: For age 18 or younger, glasses (frames and lenses) and/or contact lenses. Once the $250 maximum is reached, member cost sharing will apply, deductible then 20% coinsurance. Additional coatings not covered.
	Children's dental check-up	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.)

- Bariatric surgery
- 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 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
- Acupuncture
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)
- 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.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 1-888-246-1370 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? 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 1-866-281-1464.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-281-1464.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-281-1464.

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	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	20%
Other coinsurance	12%

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	$2,500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	20%
Other copayment	$20

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	$800
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	20%
Other copayment	$100

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	$2,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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