




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, <http://PacificSource.com/oregon/large-2018>. 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 <http://www.dol.gov/ebsa/healthreform> or call 1-888-977-9299 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	Deschutes County Onsite Clinic <u>provider</u> : \$0   PacificSource Network (PSN) participating <u>provider</u> and Non-participating <u>provider</u> : \$500 person / \$1,500 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Deschutes County Onsite Clinic <u>provider</u> : all available services through the clinic. PSN participating <u>provider</u> and Non-participating <u>provider</u> : preventive care; office visits; specialist visits; advanced diagnostic imaging; diagnostic and therapeutic radiology and lab; dialysis; urgent care professional. Rx drugs. Vision age 18 and younger: vision exam and hardware.	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Medical: Deschutes County Onsite Clinic <u>provider</u> : \$0   PSN participating <u>provider</u> : \$2,000 person / \$6,000 family   Non-participating <u>provider</u> : \$4,000 person / \$12,000 family Rx: \$1,200 person / \$3,200 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://providerdirectory.PacificSource.com/?nPlan=PSN">http://providerdirectory.PacificSource.com/?nPlan=PSN</a> or call 1-888-246-1370 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-</u>

		<u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Deschutes County Onsite Clinic Provider (You will pay the least)	PacificSource Network Participating Providers (You will pay more)	Non-participating Providers (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, <u>deductible</u> does not apply	\$25 <u>co-pay</u> /visit, <u>deductible</u> does not apply	\$25 <u>co-pay</u> /visit, then 20% <u>co-insurance</u> , <u>deductible</u> does not apply	None
	<u>Specialist</u> visit				None
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply Not available: Well baby/well child care, Routine mammograms, Routine and diagnostic colonoscopy, prostate cancer screening, routine electron beam tomography (EBT)	No charge, <u>deductible</u> does not apply	20% <u>co-insurance</u> , <u>deductible</u> does not apply	Routine 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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge, <u>deductible</u> does not apply	20% <u>co-insurance</u> , <u>deductible</u> does not apply	40% <u>co-insurance</u> , <u>deductible</u> does not apply	None
	Imaging (CT/PET scans, MRIs)	Not available			<u>Preauthorization</u> required.
If you need drugs to treat your illness or condition	Generic drugs	Deschutes County Onsite Clinic: Retail: \$4 <u>co-pay</u> , <u>deductible</u> does not apply Mail: \$4 <u>co-pay</u> , <u>deductible</u> does not apply	Northwest Pharmacy Services: Retail: \$20 <u>co-pay</u> , <u>deductible</u> does not apply WellPartner: Mail: \$40 <u>co-pay</u> , <u>deductible</u> does not apply	50% <u>co-insurance</u> , <u>deductible</u> does not apply	<u>Preauthorization</u> required for certain drugs. Deschutes County Onsite Clinic: Retail limited to 90 day supply. Mail limited to 90 day supply.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Deschutes County Onsite Clinic Provider (You will pay the least)	PacificSource Network Participating Providers (You will pay more)	Non-participating Providers (You will pay the most)	
	Formulary drugs	Deschutes County Onsite Clinic: Retail: \$40 <u>co-pay</u> , <u>deductible</u> does not apply Mail: \$40 <u>co-pay</u> , <u>deductible</u> does not apply	Northwest Pharmacy Services: Retail: Greater of 20% <u>co-insurance</u> or \$50 <u>co-pay</u> up to a maximum of \$100 <u>co-pay</u> , <u>deductible</u> does not apply WellPartner: Mail: Greater of 20% <u>co-insurance</u> or \$100 <u>co-pay</u> up to a maximum of \$200 <u>co-pay</u> , <u>deductible</u> does not apply	50% <u>co-insurance</u> , <u>deductible</u> does not apply	Northwest Pharmacy Services: Retail Only: Limited to a 34 day supply. WellPartner: Mail Only: Limited to a 100 day supply. Non-participating pharmacy: Receipts must be submitted directly to Northwest Pharmacy Services for reimbursement.
	Non-Formulary drugs	Deschutes County Onsite Clinic: Retail: \$80 <u>co-pay</u> , <u>deductible</u> does not apply Mail: \$80 <u>co-pay</u> , <u>deductible</u> does not apply	Northwest Pharmacy Services: Retail: Greater of 20% <u>co-insurance</u> or \$75 <u>co-pay</u> up to a maximum of \$125 <u>co-pay</u> , <u>deductible</u> does not apply WellPartner: Mail: Greater of 20% <u>co-insurance</u> or \$150 <u>co-pay</u> up to a maximum of \$300 <u>co-pay</u> , <u>deductible</u> does not apply	50% <u>co-insurance</u> , <u>deductible</u> does not apply	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not available	<u>Deductible</u> then 20% <u>co-insurance</u>	<u>Deductible</u> then 40% <u>co-insurance</u>	None
	Physician/surgeon fees				
<b>If you need immediate</b>	Emergency room services	Not available	Medical Emergency: <u>Deductible</u> then	Medical Emergency: <u>Deductible</u> then	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Deschutes County Onsite Clinic Provider (You will pay the least)	PacificSource Network Participating Providers (You will pay more)	Non-participating Providers (You will pay the most)	
medical attention			\$100 <u>co-pay/admit</u> , plus 20% <u>co-insurance</u>  Non-Emergency: Not covered	\$100 <u>co-pay/admit</u> , plus 20% <u>co-insurance</u>  Non-Emergency: Not covered	
	<u>Emergency medical transportation</u>	Not available	Ground: <u>Deductible</u> then 20% <u>co-insurance</u> Air: <u>Deductible</u> then 20% <u>co-insurance</u>	Ground: <u>Deductible</u> then 20% <u>co-insurance</u> Air: <u>Deductible</u> then 20% <u>co-insurance</u>	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	<u>Urgent care</u>	Professional: No charge, <u>deductible</u> does not apply Facility: No charge, <u>deductible</u> does not apply	Professional: \$25 <u>co-pay/visit</u> , <u>deductible</u> does not apply Facility: <u>Deductible</u> then 20% <u>co-insurance</u>	Professional: \$25 <u>co-pay/visit</u> , then 20% <u>co-insurance</u> , <u>deductible</u> does not apply Facility: <u>Deductible</u> then 20% <u>co-insurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not available	<u>Deductible</u> then \$100 <u>co-pay/admit</u> , then 20% <u>co-insurance</u>	<u>Deductible</u> then \$100 <u>co-pay/admit</u> , then 40% <u>co-insurance</u>	Limited to semi-private room unless intensive or coronary care units, <u>medically necessary</u> isolation, or hospital only has private rooms. <u>Preauthorization</u> required for some inpatient services.
	Physician/surgeon fees	Not available	<u>Deductible</u> then 20% <u>co-insurance</u>	<u>Deductible</u> then 40% <u>co-insurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge, <u>deductible</u> does not apply	\$25 <u>co-pay/visit</u> , <u>deductible</u> does not apply	\$25 <u>co-pay/visit</u> , then 20% <u>co-insurance</u> , <u>deductible</u> does not apply	None
	Inpatient services	Not available	<u>Deductible</u> then 20% <u>co-insurance</u>	<u>Deductible</u> then 40% <u>co-insurance</u>	<u>Preauthorization</u> required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Deschutes County Onsite Clinic Provider (You will pay the least)	PacificSource Network Participating Providers (You will pay more)	Non-participating Providers (You will pay the most)	
If you are pregnant	Office visits	Not available	88% <u>co-insurance</u> , <u>deductible</u> does not apply	Deductible then 40% <u>co-insurance</u>	Cost sharing does not apply to certain 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		Deductible then 20% <u>co-insurance</u>		
If you need help recovering or have other special health needs	<u>Home health care</u>	Not available	Deductible then 20% <u>co-insurance</u>	Deductible then 40% <u>co-insurance</u>	No coverage for private duty nursing or custodial care. <u>Preauthorization</u> required. Limited to two visits/day, 180 visits/calendar year.
	<u>Rehabilitation services</u>	Not available	Inpatient: Deductible then 20% <u>co-insurance</u> Outpatient: Deductible then 20% <u>co-insurance</u>	Inpatient: Deductible then 40% <u>co-insurance</u> Outpatient: Deductible then 40% <u>co-insurance</u>	<u>Preauthorization</u> required. No coverage for recreation therapy. Inpatient: Covered up to 30 days/year, unless <u>medically necessary</u> to treat a mental health diagnosis. Outpatient: Covered up to 30 visits/year, unless <u>medically necessary</u> to treat a mental health diagnosis. Includes vision therapy. Up to 30 additional visits for head and spinal injury, cardiovascular accident, stroke or major injury.
	<u>Habilitation services</u>				
	<u>Skilled nursing care</u>	Not available	Deductible then 20% <u>co-insurance</u>	Deductible then 40% <u>co-insurance</u>	Limited to 60 days/year. No coverage for custodial care. <u>Preauthorization</u> required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Deschutes County Onsite Clinic Provider (You will pay the least)	PacificSource Network Participating Providers (You will pay more)	Non-participating Providers (You will pay the most)	
	<u>Durable medical equipment</u>	Not available	<u>Deductible</u> then 20% <u>co-insurance</u>	<u>Deductible</u> then 40% <u>co-insurance</u>	Limited to: \$5,000/year overall; one pair/year for glasses or contact lenses; age 18 and younger one/ear every 48 months for hearing aid; age 19 and older one/ear limited to \$2,500 every 24 months for hearing aid; one breast pump/pregnancy; \$150/year for wig for chemotherapy or radiation therapy. <u>Preauthorization</u> required if equipment is over \$1000 and for power-assisted wheelchairs.
	<u>Hospice services</u>				
If your child needs dental or eye care	Children's eye exam	Not available	No charge, <u>deductible</u> does not apply		One routine eye exam/calendar year for age 18 or younger.
	Children's glasses		No charge, <u>deductible</u> does not apply, for one pair per year		Combined participating and non-participating: For age 18 or younger, one pair of glasses (frames and lenses) or contact lenses in lieu of glasses per benefit year. Additional coatings not covered.
	Children's dental check-up	Not covered			

## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Abortion (except in cases of rape, incest or to save the life of the mother)</li><li>• Bariatric surgery</li><li>• Cosmetic surgery (except in certain situations)</li></ul>	<ul style="list-style-type: none"><li>• Custodial care</li><li>• Dental care (Adult)</li><li>• Dental check-up (Child)</li><li>• Infertility treatment</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li><li>• Routine foot care, other than with diabetes mellitus</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (Child)</li><li>• Hearing aids (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Weight loss programs</li></ul>

**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 [www.cciio.cms.gov](http://www.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 <http://www.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](http://dfr.oregon.gov).

### Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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 1-888-977-9299.

—————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** \$500
- **Specialist** \$25 co-payment
- **Hospital (facility)** 20% co-insurance
- **Other** \$100 co-payment

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$210
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,270</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$500
- **Specialist** \$25 co-payment
- **Hospital (facility)** 20% co-insurance
- **Other** \$100 co-payment

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$260
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,420</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$500
- **Specialist** \$25 co-payment
- **Hospital (facility)** 20% co-insurance
- **Other** \$100 co-payment

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,500</b>
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**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$380
<u>Coinsurance</u>	\$220
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>