



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, go to PacificSource.com/plan-details. 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 1-866-556-1224 to request a copy.

Important Questions	Answers	Why this Matters:
<u>What is the overall deductible?</u>	<u>In-network provider</u> : \$2,000 individual/\$4,000 family <u>Out-of-network provider</u> : \$10,000 individual/\$20,000 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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive care</u> and other services listed below with ' <u>deductible</u> does not apply'.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at Healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other <u>deductibles</u> for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the <u>out-of-pocket</u> limit for this <u>plan</u>?</u>	<u>In-network provider</u> : \$6,000 individual/\$12,000 family <u>Out-of-network provider</u> : \$25,000 individual/\$50,000 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.
<u>What is not included in the <u>out-of-pocket limit</u>?</u>	<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> .
<u>Will you pay less if you use a <u>network provider</u>?</u>	Yes. See providerdirectory.PacificSource.com/Commercial/?nPlan=Navigator or call 1-866-556-1224 for a list of network providers.	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-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a <u>referral</u> to see a <u>specialist</u>?</u>	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.

What You Will Pay				
Common Medical Event	Services You May Need	In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>co-pay/visit</u> , <u>deductible</u> does not apply	50% <u>co-insurance</u>	None
	<u>Specialist</u> visit	\$40 <u>co-pay/visit</u> , <u>deductible</u> does not apply	50% <u>co-insurance</u>	None
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge, <u>deductible</u> does not apply	50% <u>co-insurance</u>	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. Tobacco cessation: Not covered out-of-network.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>co-insurance</u>	50% <u>co-insurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>co-insurance</u>	50% <u>co-insurance</u>	Prior authorization required. If not received, you will be responsible for the expense.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at PacificSource.com/drug-list	Generic drugs - Tier 1	Retail: \$15 <u>co-pay/prescription</u> , <u>deductible</u> does not apply Mail: \$30 <u>co-pay/prescription</u> , <u>deductible</u> does not apply	90% <u>co-insurance</u>	For all <u>prescription drug</u> list tiers: Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, <u>deductible</u> does not apply. <u>Cost share</u> amounts shown represent a 30 day supply at retail and a 90 day supply at mail order. Quantity for retail and mail order are limited to a 90 day supply. Quantity for <u>Specialty drug</u> is limited to 30 day supply. Prior authorization required for certain drugs. If not received, you will be responsible for the expense.
	Preferred drugs - Tier 2	Retail: \$70 <u>co-pay/prescription</u> , <u>deductible</u> does not apply Mail: \$210 <u>co-pay/prescription</u> , <u>deductible</u> does not apply	90% <u>co-insurance</u>	
	Non-preferred drugs - Tier 3	Retail: 20% <u>co-insurance</u> , <u>deductible</u> does not apply Mail: 20% <u>co-insurance</u> , <u>deductible</u> does not apply	90% <u>co-insurance</u>	
	<u>Specialty drugs</u> - Tier 4	Retail: 20% <u>co-insurance</u> , <u>deductible</u> does not apply	90% <u>co-insurance</u>	

What You Will Pay				
Common Medical Event	Services You May Need	In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Mail: 20% <u>co-insurance</u> , <u>deductible</u> does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>co-insurance</u>	50% <u>co-insurance</u>	Prior authorization required for some surgeries. If not received, you will be responsible for the expense.
	Physician/surgeon fees	20% <u>co-insurance</u>	50% <u>co-insurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Medical emergency: 20% <u>co-insurance</u> Non-emergency: 20% <u>co-insurance</u>	Medical emergency: 20% <u>co-insurance</u> Non-emergency: 50% <u>co-insurance</u>	None
	<u>Emergency medical transportation</u>	Ground: 20% <u>co-insurance</u> Air: 20% <u>co-insurance</u>	Ground: 20% <u>co-insurance</u> Air: 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>	\$20 <u>co-pay/visit</u> , <u>deductible</u> does not apply	50% <u>co-insurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>co-insurance</u>	50% <u>co-insurance</u>	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% <u>co-insurance</u>	50% <u>co-insurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$20 <u>co-pay/visit</u> , <u>deductible</u> does not apply Other outpatient care: 20% <u>co-insurance</u>	50% <u>co-insurance</u>	None
	Inpatient services	20% <u>co-insurance</u>	50% <u>co-insurance</u>	Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.
If you are pregnant	Office visits	20% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Cost sharing does not apply for preventive services</u> . Delivery and hospital visits are covered under prenatal and postnatal care.

What You Will Pay				
Common Medical Event	Services You May Need	In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery professional services	20% <u>co-insurance</u>	50% <u>co-insurance</u>	Facility is covered the same as any other hospital services.
	Childbirth/delivery facility services	20% <u>co-insurance</u>	50% <u>co-insurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>co-insurance</u>	50% <u>co-insurance</u>	Limited to 130 visits/year. No coverage for private duty nursing or custodial care.
	<u>Rehabilitation services</u>	Inpatient: 20% <u>co-insurance</u> Outpatient: 20% <u>co-insurance</u>	Inpatient: 50% <u>co-insurance</u> Outpatient: 50% <u>co-insurance</u>	Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	<u>Habilitation services</u>	Inpatient: 20% <u>co-insurance</u> Outpatient: 20% <u>co-insurance</u>	Inpatient: 50% <u>co-insurance</u> Outpatient: 50% <u>co-insurance</u>	Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	<u>Skilled nursing care</u>	20% <u>co-insurance</u>	50% <u>co-insurance</u>	Limited to 60 days/year. No coverage for custodial care.
	<u>Durable medical equipment</u>	20% <u>co-insurance</u>	50% <u>co-insurance</u>	Limited to: one pair/year for glasses or contact lenses; one manual or electric breast pump/pregnancy; \$150/year for wig for chemotherapy or radiation therapy. Prior authorization required in certain circumstances, if not received, you will be responsible for the expense.
	<u>Hospice services</u>	20% <u>co-insurance</u>	50% <u>co-insurance</u>	No coverage for private duty nursing. Respite care limited to 14 days lifetime.
If your child needs dental or eye care	Children's eye exam	No charge, <u>deductible</u> does not apply	No charge up to \$40 maximum, <u>deductible</u> does not apply, then 100% <u>co-insurance</u>	For age 18 or younger, two routine eye exams/year.
	Children's glasses	Combined in-network and out-of-network: 20% <u>co-insurance</u>	Combined in-network and out-of-network: 20% <u>co-insurance</u>	Combined in-network and out-of-network: For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) per year. No charge up to \$150 maximum, <u>deductible</u> does not apply.

What You Will Pay				
Common Medical Event	Services You May Need	In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's dental check-up	No charge, <u>deductible</u> does not apply	20% <u>co-insurance, deductible</u> does not apply	Limited to two exams/year.

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"> • Bariatric surgery • Cosmetic surgery (except in certain situations) • Dental care (Adult) • Hearing aids (Adult) 	<ul style="list-style-type: none"> • Hearing aids (Child) • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) • 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • Abortion • Acupuncture - 12 visits/year 	<ul style="list-style-type: none"> • Chiropractic care - 12 visits/year 	<ul style="list-style-type: none"> • 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: Office of the Insurance Commissioner at 1-800-562-6900 or at insurance.wa.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 1-866-556-1224 or the Office of the Insurance Commissioner at 1-800-562-6900 or at insurance.wa.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? Not Applicable.

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 1-866-556-1224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-556-1224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-556-1224.

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 <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u>	\$40 <u>co-payment</u>
■ <u>Hospital (facility)</u>	20% <u>co-insurance</u>
■ <u>Other</u>	20% <u>co-insurance</u>

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	\$2000
Copayments	\$10
Coinsurance	\$2100

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$4,170

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u>	\$40 <u>co-payment</u>
■ <u>Hospital (facility)</u>	20% <u>co-insurance</u>
■ <u>Other</u>	20% <u>co-insurance</u>

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	\$900
Copayments	\$1300
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u>	\$40 <u>co-payment</u>
■ <u>Hospital (facility)</u>	20% <u>co-insurance</u>
■ <u>Other</u>	20% <u>co-insurance</u>

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	\$2000
Copayments	\$100
Coinsurance	\$90

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$2,190

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

Discrimination Is Against the Law

PacificSource Health Plans ("PacificSource") complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual identity. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual identity.

PacificSource:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at (888) 977-9299.

If you believe that PacificSource has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual identity, you can file a grievance with: Civil Rights Coordinator, PO Box 7068, Springfield, OR 97475-0068, (888) 977-9299, TTY: 711, Fax (541) 684-5264, or email CRC@pacificsource.com. Please indicate your wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Service Department is available to help you.

You can also file a civil rights complaint with:

The U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at <https://insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241(TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

Russian	Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через PacificSource Health Plans. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страховового покрытия или помочь с расходами. Вы имеете право на бесплатное получение этой информации и помочь на вашем языке. Звоните по телефону (888) 977-9299.
Serbo-Croatian	U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko PacificSource Health Plans. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoći pri plaćanju. Imate pravo da ove informacije, kao i pomoći, dobijete besplatno na svom jeziku. Nazovite (888) 977-9299.
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de PacificSource Health Plans. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (888) 977-9299.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng PacificSource Health Plans. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa (888) 977-9299.
Thai	ประกาศนี้มีข้อมูลสำคัญประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือของบุคคลที่มีสุขภาพของคุณผ่าน PacificSource Health Plans ดูรายละเอียดการในประกาศนี้คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่ายคุณมีสิทธิ์ที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่ายโดย (888) 977-9299.
Ukrainian	Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через PacificSource Health Plans. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону (888) 977-9299.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin nộp hoặc hợp đồng bảo hiểm qua chương trình PacificSource Health Plans. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình hoàn toàn miễn phí. Xin gọi số (888) 977-9299.