PacificSource HEALTH PLANS

Medical Benefit Summary
Navigator HSA 1700_20+Rx S3 Non-embedded

Marion County Non-MCLEA

Benefit Year: Calendar Year

Provider Network: Navigator

Deductible Per Benefit Year	In-network and Out-of-network	
Individual/Family	$1,700/$3,400	
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$3,000/$6,000	$7,600/$15,200

Note: In-network out-of-pocket limit accumulates separately from the out-of-network out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain situations bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your handbook.

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	After deductible, 40%
Preventive physicals	No deductible, 0%	After deductible, 40%
Well woman visits	No deductible, 0%	After deductible, 40%
Preventive mammograms	No deductible, 0%	After deductible, 40%
Immunizations	No deductible, 0%	After deductible, 40%
Preventive colonoscopy	No deductible, 0%	After deductible, 40%
Prostate cancer screening	No deductible, 0%	After deductible, 40%
Professional Services		
PCP office and home visits	First three visits after deductible, 0%. Subsequent visits, after deductible, 20%*	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Naturopath office visits	After deductible, 20%	After deductible, 40%
Specialist office and home visits	After deductible, 20%	After deductible, 40%
Telehealth visits	First three visits after deductible, 0%. Subsequent visits, after deductible, 20%*	After deductible, 40%
Office procedures and supplies	After deductible, 20%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%
Outpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Acupuncture (12 visits per benefit year)	After deductible, 20%	After deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits per benefit year)	After deductible, 20%	After deductible, 40%
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	After deductible, 20%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 40%
Outpatient at ambulatory surgery center	After deductible, 10%	After deductible, 40%
Diagnostic imaging – advanced	After deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After deductible, 20%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	After deductible, 20%	After deductible, 40%
Emergency room visits – medical emergency	After deductible, 20%	After deductible, 20%
Emergency room visits – non-emergency	After deductible, 20%	After deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 20%	After deductible, 40%
Hospital/Facility services	After deductible, 20%	After deductible, 40%
Mental Health and Substance Use Disorder Services		
Office visits	First three visits after deductible, 0%. Subsequent visits, after deductible, 20%*	After deductible, 40%
Inpatient care	After deductible, 20%	After deductible, 40%
Residential programs	After deductible, 20%	After deductible, 40%
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 40%
Durable medical equipment	After deductible, 20%	After deductible, 40%
Home health services	After deductible, 20%	After deductible, 40%
Transplants	After deductible, 20%	After deductible, 40%

This is a brief summary of benefits. Refer to your handbook for additional information or a further explanation of benefits, limitations, and exclusions.

*First three visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, copayment, or coinsurance.

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, you and your dependents must satisfy the family deductible before benefits are paid.

In-network expense and out-of-network expense apply together toward your deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered services during the benefit year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services for the rest of that benefit year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, you and your dependents must satisfy the family out-of-pocket limit. Be sure to check your handbook, as there are some charges, such as non-essential health benefits, penalties, and balance billed amounts that do not count toward the out-of-pocket limit.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
OR 0_20P 1700D S4 PDL

Marion County Non-MCLEA

Benefit Year: Calendar Year

Formulary: Preferred Drug List (PDL)

This plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal healthcare reform. To check which tier your prescription falls under, call our Customer Service team or visit PacificSource.com/find-a-drug.

The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's out-of-network out-of-pocket limit which is shown on the Medical Benefit Summary. The copayment and/or coinsurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the benefit year in which you have satisfied the medical out-of-pocket limit.

Medical Deductible

You must meet the medical deductible, which is shown on the Medical Benefit Summary, before your prescription drug benefits begin.

PacificSource Expanded (Preventive) No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0 copay. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com and select Find a Drug.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties when filled at an in-network pharmacy. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

Each time a covered prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

Service/ Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
In-network Retail Pharmacy				
Up to a 90 day supply:	No deductible, 0%	After deductible, 20%*	After deductible, 20%*	After deductible, 20%*
In-network Mail Order Pharmacy				
Up to a 90 day supply:	No deductible, 0%	After deductible, 20%*	After deductible, 20%*	After deductible, 20%*

Service/ Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Compound Drugs**				
Up to a 90 day supply:		After deductible, 20%		
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:		After deductible, 50%		
				Tier 1, Tier 2, and Tier 3 Member Pays
Specialty Drugs - In-network Specialty Pharmacy				
Up to a 30 day supply:			After deductible, 20%	
Specialty Drugs - Out-of-network Specialty Pharmacy				
30 day maximum fill, no more than three fills allowed per year:			After deductible, 20%	

*Prescription insulin is not subject to a deductible and is limited to $35 copay per 30 day supply when filled at an in-network pharmacy.

**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

MAC A - Regardless of the reason or medical necessity, if you receive a brand name drug or if your provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's copayment and/or coinsurance plus the difference in cost between the brand name and generic drug after the medical deductible is met. The cost difference between the brand name and generic drug does not apply toward the medical deductible or out-of-pocket limit. Does not apply to preventive bowel prep kits covered under USPSTF guidelines.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to exception review for coverage at no charge.

See your handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.

PacificSource HEALTH PLANS

Marion County Non-MCLEA

Vision Benefit Summary
Vision Plus S3

Benefit Year: Calendar Year

The following shows the vision benefits available under this plan for all covered vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Coverage for pediatric services will end on the last day of the month in which the member turns 19. Copayment and/or coinsurance for covered charges apply to the medical plan's out-of-pocket limit.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Members Age 18 and Younger		
Eye exam	No deductible, $10	No deductible, $10 then 0% up to $45 then 100%
Vision hardware	No deductible, 0% for one pair per year for frames or lenses	No deductible, 0% for one pair per year up to $75 then 100% for frames and/or lenses
Members Age 19 and Older		
Eye exam	No deductible, $10	No deductible, $10 then 0% up to $45 then 100%
Single vision lenses	No deductible, 0%	No deductible, 0% up to $30 then 100%
Bifocal lenses	No deductible, 0%	No deductible, 0% up to $50 then 100%
Trifocal lenses	No deductible, 0%	No deductible, 0% up to $65 then 100%
Lenticular lenses	No deductible, 0%	No deductible, 0% up to $100 then 100%
Progressive lenses	No deductible, 0%	No deductible, 0% up to $50 then 100%
Lens treatments	No deductible, 0% up to $50 then 100%	Included in lenses allowance
Frames	No deductible, 0% up to $200 then 100%	No deductible, 0% up to $70 then 100%
Contact Lenses (in lieu of glasses)		
Contact lenses	No deductible, 0% up to $200 then 100%	No deductible, 0% up to $105 then 100%

Benefit Limitations: members age 18 and younger

- One vision exam every benefit year.
- Vision hardware includes glasses (lenses and frames) or contacts (lenses and fitting) once per benefit year.

Benefit Limitations: members age 19 and older

- One vision exam every benefit year.
- Lenses: One pair every benefit year.
- Frames: Once every benefit year.
- Contact lenses: Once every benefit year.
- Elective contact lenses are in lieu of frames and lenses.
- Anti-reflective coatings, scratch resistant coatings, lens tints and polycarbonate lenses are covered.

Exclusions

- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.
- Duplication of spare eyeglasses or any lenses or frames for members age 18 and younger.
- Expenses covered under any workers' compensation law.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Medical or surgical treatment of the eye.
- Non-prescription lenses.
- Plano contact lenses.
- Replacement of lost, stolen, or broken lenses or frames.
- Services or supplies not listed as covered services.
- Services or supplies received before this plan's coverage begins or after it ends.
- Special procedures, such as orthoptics or vision training.
- Special supplies, such as sunglasses and subnormal vision aids.
- Visual analysis that does not include refraction.

Important information about your vision benefits

Your plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

In-network Providers: PacificSource is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.

Paying for Services: Our provider contracts require in-network providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits.

In-network providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as copayments and amounts over your plan's maximum benefit.

If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and they should bill PacificSource directly.

Sales and Special Promotions (sales and promotions are not considered insurance): Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because in-network providers already discount their services through their contract with PacificSource, your plan's in-network benefits cannot be combined with any other discounts or coupons. You can use your plan's in-network benefits, or you can use your plan's out-of-network benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the in-network provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and we will reimburse you according to your plan's out-of-network benefits.

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 1-888-977-9299 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,700 individual/$3,400 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, the overall family deductible must be met before the plan begins to pay.
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?	In-network provider: $3,000 individual/$6,000 family | Out-of-network provider: $7,600 individual/$15,200 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, the overall family out-of-pocket limit must be 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/Commercial/?nPlan=Navigator or call 1-888-977-9299 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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.

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	First three visits no charge. Subsequent visits, 20% co-insurance.	40% co-insurance	First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Specialist visit	20% co-insurance	40% co-insurance	None
	Preventive care/screening/immunization	No charge, deductible does not apply	40% co-insurance	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. Tobacco cessation: Not covered out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	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 prescription drug coverage is available at PacificSource.com/drug-list	Generic drugs - Tier 1	Retail: 20% co-insurance Incentive: No charge, deductible does not apply Mail: 20% co-insurance Incentive: No charge, deductible does not apply	50% co-insurance	For all prescription drug list tiers: Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, deductible does not apply. Cost share 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 Specialty drug 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: 20% co-insurance Mail: 20% co-insurance	50% co-insurance	
	Non-preferred drugs - Tier 3	Retail: 20% co-insurance Mail: 20% co-insurance	50% co-insurance	
	Specialty drugs	20% co-insurance	20% co-insurance	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance Ambulatory surgery center: 10% co-insurance	40% co-insurance	Prior authorization required for some surgeries. If not received, you will be responsible for the expense.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	None
If you need immediate medical attention	Emergency room care	Medical emergency: 20% co-insurance Non-emergency: 20% co-insurance	Medical emergency: 20% co-insurance Non-emergency: 20% co-insurance	None
	Emergency medical transportation	Ground: 20% co-insurance Air: 20% co-insurance	Ground: 20% co-insurance Air: 20% co-insurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	Urgent care	20% co-insurance	40% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	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% co-insurance	40% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First three visits no charge. Subsequent visits, 20% co-insurance.	40% co-insurance	First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Inpatient services	20% co-insurance	40% co-insurance	Prior authorization required for some inpatient services. If not received, you will be responsible for the expense.
If you are pregnant	Office visits	20% co-insurance	40% co-insurance	Cost sharing does not apply for 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	20% co-insurance	40% co-insurance	
	Childbirth/delivery facility services	20% co-insurance	40% co-insurance	

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 need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Limited to 140 visits/year. No coverage for private duty nursing or custodial care.
	Rehabilitation services	Inpatient: 20% co-insurance Outpatient: 20% co-insurance	Inpatient: 40% co-insurance Outpatient: 40% co-insurance	Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	Habilitation services	Inpatient: 20% co-insurance Outpatient: 20% co-insurance	Inpatient: 40% co-insurance Outpatient: 40% co-insurance	Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy.
	Skilled nursing care	20% co-insurance	40% co-insurance	Limited to 60 days/year. No coverage for custodial care.
	Durable medical equipment	20% co-insurance	40% co-insurance	Limited to: one pair/year for glasses or contact lenses; one breast pump/pregnancy; $150/year for wig for chemotherapy or radiation therapy. Prior authorization required if equipment is over $2,500 and for power-assisted wheelchairs, if not received, you will be responsible for the expense.
	Hospice services	20% co-insurance	40% co-insurance	No coverage for private duty nursing. Respite care limited to a combined inpatient and outpatient 14 days lifetime.
If your child needs dental or eye care	Children's eye exam	$10 co-pay, deductible does not apply	$10 co-pay, deductible does not apply, up to $45 maximum then 100% co-insurance	For age 18 or younger, one routine eye exam/year.
	Children's glasses	No charge, deductible does not apply	No charge, deductible does not apply, up to $75 then 100% co-insurance	For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) per year.
	Children's dental check-up	Not covered	Not covered	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
- Hearing aids (Adult)
- Non-emergency care when traveling outside the U.S.

- Cosmetic surgery (except in certain situations)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- 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, 12 visits/year
- Chiropractic care, 20 visits/year
- Hearing aids (Child)
- 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.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 1-888-977-9299 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 1-888-977-9299.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-977-9299.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 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** $1,700
- **Specialist** 20% co-insurance
- **Hospital (facility)** 20% co-insurance
- **Other** 20% co-insurance

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	$1700
Copayments	$0
Coinsurance	$1300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

- **The plan's overall deductible** $1,700
- **Specialist** 20% co-insurance
- **Hospital (facility)** 20% co-insurance
- **Other** 20% co-insurance

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	$1700
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

- **The plan's overall deductible** $1,700
- **Specialist** 20% co-insurance
- **Hospital (facility)** 20% co-insurance
- **Other** 20% co-insurance

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	$1700
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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