
 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 <http://www.eugene.gov/employeebenefits> or by calling 541-682-5062. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [co-insurance](#), [co-payment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 541-682-5062 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$150/individual or \$450/family	Generally, you must pay all the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Doesn't apply to preventive care, some services due to accidental injury, outpatient surgery physician/facility charges, and routine exams/hardware under vision plan. Combined deductible for medical and retail pharmacy.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">co-payment</a> or <a href="#">co-insurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	Yes. Dental care other than preventive care: \$50/individual or \$150/family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$850/individual	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , mail-order pharmacy <a href="#">co-payments</a> , deductibles, <a href="#">balance-billing</a> charges, dental benefits and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.PacificSource.com">www.PacificSource.com</a> or call 1-888-532-5332 for medical/vision/pharmacy, or see <a href="http://www.modahealth.com">www.modahealth.com</a> or call 1-888-217-2365 for dental, for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware your <a href="#">in-network provider</a> may use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146  
Released on April 6, 2016

 All [co-payment](#) and [co-insurance](#) 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*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	None
	<a href="#">Specialist</a> visit	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	None
	Other practitioner office visit Acupuncture Chiropractic Care Massage Therapy Naturopath	20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	None Chiropractic 52 visits/cal yr limit Massage Therapy \$300/cal yr limit Naturopath \$300/cal yr limit. No coverage for naturopathic and homeopathic remedies and prescriptions.
	<a href="#">Preventive care/screening</a> /Immunization Routine Physicals Well Baby/Child Visit Routine Gynecological Exam Tobacco Cessation Immunizations Preventive Colonoscopy	No charge No charge No charge No charge No charge No charge  <a href="#">Deductible</a> does not apply	50% <a href="#">co-insurance</a> 50% <a href="#">co-insurance</a> 50% <a href="#">co-insurance</a> No charge 50% <a href="#">co-insurance</a> 50% <a href="#">co-insurance</a>  <a href="#">Deductible</a> does not apply	Limited to: Routine Physicals/Well Baby: no visit max ages 0-12 months, 2 per year ages 1-2, and annually ages 2 and older. Routine Gynecological Exam: annually. Tobacco Cessation: age 15 or older. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	None

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.eugene-or.gov/253/Employee-Benefits>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		<a href="#">Deductible</a> does not apply for treatment of accidental injury	<a href="#">Deductible</a> does not apply for treatment of accidental injury	
	Imaging (CT/PET scans, MRIs)	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.pacificsource.com/drug-list/">https://www.pacificsource.com/drug-list/</a>	Generic drugs	Retail: \$10 <a href="#">co-pay</a> /prescription  Mail-order: \$10 <a href="#">co-pay</a> /prescription, <a href="#">Deductible</a> does not apply	Retail: \$10 <a href="#">co-pay</a> /prescription	Retail day supply unlimited. Mail limited to 90-day supply. <a href="#">Preauthorization</a> required for certain drugs. Retail drugs subject to medical deductible of \$150/individual or \$450/family and medical out-of-pocket limit of \$850/year. Once out-of-pocket limit reached, <a href="#">co-pays</a> for drugs obtained from a participating retail pharmacy are waived for the remainder of year. Differential between generic and brand drugs, and non-participating retail pharmacy charges do not apply to the out-of-pocket limit.
	Preferred brand drugs	Retail: 20% <a href="#">co-insurance</a>  Mail order: \$20 <a href="#">co-pay</a> /prescription, <a href="#">Deductible</a> does not apply	Retail: 20% <a href="#">co-insurance</a>	
	Non-preferred brand drugs	Retail: 25% <a href="#">co-insurance</a>  Mail: \$25 <a href="#">co-pay</a> or 25% <a href="#">co-insurance</a> , whichever is greater (\$60 max <a href="#">co-pay</a> ), <a href="#">Deductible</a> does not apply	Retail: 25% <a href="#">co-insurance</a>	
	<a href="#">Specialty drugs</a>	Retail: 25% <a href="#">co-insurance</a>  Mail: \$25 <a href="#">co-pay</a> or 25% <a href="#">co-insurance</a> , whichever is greater (\$60 max <a href="#">co-pay</a> ), <a href="#">Deductible</a> does not apply	Retail: 25% <a href="#">co-insurance</a>	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply	None
	Physician/surgeon fees	No charge <a href="#">Deductible</a> does not apply	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury.	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury.	Non-participating paid as participating if emergency medical condition.
	<a href="#">Emergency medical transportation</a> Ground Ambulance Air Ambulance	No charge <a href="#">Deductible</a> does not apply	No charge <a href="#">Deductible</a> does not apply	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	<a href="#">Urgent care</a>	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury.	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. <a href="#">Preauthorization</a> required for inpatient elective surgery.
	Physician/surgeon fees	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">co-insurance</a>	20% <a href="#">co-insurance</a>	None
	Inpatient services	20% <a href="#">co-insurance</a>	20% <a href="#">co-insurance</a>	<a href="#">Preauthorization</a> required.
If you are pregnant	Office visits	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	Depending on the type of services, a <a href="#">co-payment</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	
	Childbirth/delivery facility services Free Standing Birthing Centers	20% <a href="#">co-insurance</a> No charge	50% <a href="#">co-insurance</a> 50% <a href="#">co-insurance</a>	

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.eugene-or.gov/253/Employee-Benefits>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">co-insurance</a>	Limited to 100 four-hour visits/calendar year. <a href="#">Preauthorization</a> required. No coverage for private duty nursing.
	<a href="#">Rehabilitation services</a> Inpatient Outpatient	20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	<a href="#">Preauthorization</a> required. Includes physical therapy, speech therapy, and occupational therapy. No coverage for recreational therapy.
	<a href="#">Habilitation services</a> Inpatient Outpatient	20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	
	<a href="#">Skilled nursing care</a>	50% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	Limited to 60 days/calendar year. <a href="#">Preauthorization</a> required. No coverage for custodial care.
	<a href="#">Durable medical equipment</a>	20% <a href="#">co-insurance</a>	20% <a href="#">co-insurance</a>	Must be prescribed by physician; rental covered up to rental equipment purchase price when prescribed by physician; hearing aid for children limited to one per hearing impaired ear per 48 months, hearing aids for adults limited to \$1,000 per 36 months and requires 50% co-insurance for participating and non-participating providers. <a href="#">Preauthorization</a> required over \$800.
	<a href="#">Hospice services</a>	No charge	No charge	<a href="#">Preauthorization</a> required for inpatient hospice. No coverage for private duty nursing.

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.eugene-or.gov/253/Employee-Benefits>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	20% <u>co-insurance</u> <u>Deductible</u> does not apply	20% <u>co-insurance</u> <u>Deductible</u> does not apply	Limited to one exam per 12 months.
	Children's glasses	No charge <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply	For children under age 19. Prescription frames and lenses OR contacts (once every 12 months). Contacts limited to the following per year: Standard (one pair annually): 1 contact lens per eye (2 lenses total); Monthly (six month supply) or Biweekly (3 month supply): 6 lenses per eye (12 lenses total); Dailies (one month supply): 30 lenses per eye (60 lenses total).
	Children's dental check-up	No charge <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply	Preventive examinations every 6 months. Age 16 and over, benefit is limited to \$250 per person first calendar year of eligibility; \$1,600 per person each calendar year thereafter.

### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Custodial care</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> </ul>	<ul style="list-style-type: none"> <li>• Outpatient recreational therapy</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>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Hearing aids</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: PacificSource at 1-888-977-9299, State of Oregon insurance department at 1-800-318-2596 (toll-free) (TTY: 855-889-4325) or [healthcare.oregon.gov](http://healthcare.oregon.gov), the U.S. Department of Labor [www.dol.gov](http://www.dol.gov), Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. 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).

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.eugene-or.gov/253/Employee-Benefits>

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 [www.HealthCare.gov](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: PacificSource Customer Service Department at 1-888-977-9299. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Oregon Insurance Division's Consumer Advocacy Unit at 1-503-947-7984 or toll-free at 1-888-877-4894.

**Does this 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 the 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](#), [co-payments](#) and [co-insurance](#)) 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](#) \$150
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Co-payments	\$0
Co-insurance	\$850
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,000</b>

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

- The [plan's](#) overall [deductible](#) \$150
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$150
Co-payments	\$0
Co-insurance	\$850
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,000</b>

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

- The [plan's](#) overall [deductible](#) \$150
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Co-payments	\$0
Co-insurance	\$350
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>