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 https://www.eugene-or.gov/employeebenefits or call 541-682-5061. 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 541-682-5061 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$150/individual or $450/family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. 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 plan covers some items and services even if you haven't yet met the deductible amount, but a co-payment or co-insurance may apply.
Are there other deductibles 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 deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$1,000/individual	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, deductibles, balance-billing charges, dental benefits 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 www.PacificSource.com or call 1-888-532-5332 for medical/vision/pharmacy, or see www.modahealth.com or call 1-888-217-2365 for dental, 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 in-network provider may 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 **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 provider's office or clinic	Primary care visit to treat an injury or illness Teladoc telehealth consults	PCP: 20% co-insurance Deductible does not apply for accidental injury. Teladoc: No charge. Deductible does not apply.	50% co-insurance Deductible does not apply for treatment of accidental injury	Teladoc consults: No charge only if Teladoc account activated through PacificSource. Standard co-insurance and/or deductible apply for other telemedicine services.
	Specialist visit	20% co-insurance Deductible does not apply for treatment of accidental injury	50% co-insurance Deductible does not apply for treatment of accidental injury	None
	Other practitioner office visit Acupuncture Chiropractic Care Massage Therapy Registered Dietician Naturopath	 20% co-insurance 20% co-insurance 20% co-insurance 20% co-insurance 20% co-insurance	 20% co-insurance 20% co-insurance 20% co-insurance 20% co-insurance 20% co-insurance	None Chiropractic 52 visits/cal yr limit Massage Therapy $300/cal yr limit Dietician $200/cal yr limit. Naturopath $300/cal yr limit. No coverage for naturopathic and homeopathic remedies and prescriptions.
	Preventive care/screening/Immunization Routine Physicals Well Baby/Child Visit Newborn nurse home visit Routine Gynecological Exam Tobacco Cessation Immunizations Preventive Colonoscopy	 20% co-insurance 20% co-insurance No charge 20% co-insurance No charge 20% co-insurance 20% co-insurance Deductible does not apply	 50% co-insurance 50% co-insurance 50% co-insurance 50% co-insurance No charge 50% co-insurance 50% co-insurance Deductible does not apply	Limited to: Routine Physicals/Well Baby: no visit limit through age 12 months, age 13-36 months covered per Health Resources & Services Administration preventative care schedule, annually age 3+ yrs. Newborn nurse home visits up to age 6 months. Tobacco Cessation: age 15+ yrs. Routine Gynecological Exam: annually. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

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 a test	Diagnostic test (x-ray, blood work)	20% co-insurance Deductible does not apply for treatment of accidental injury	50% co-insurance Deductible does not apply for treatment of accidental injury	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance Deductible does not apply for treatment of accidental injury	50% co-insurance Deductible does not apply for treatment of accidental injury	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.pacificsource.com/drug-list/	Tier 1 (mostly Generic drugs)	Retail: $10 co-pay/prescription Mail-order: $10 co-pay/prescription, Deductible does not apply	Retail: $10 co-pay/prescription	Retail day supply unlimited. Mail limited to 90-day supply. Preauthorization required for certain drugs. Retail drugs subject to medical deductible of $150/individual or $450/family. Retail and mail order subject to medical out-of-pocket limit of $1,000/year. Once out-of-pocket limit reached, co-pays for drugs obtained from a participating 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.
	Tier 2 (Preferred brand drugs, some Generic drugs)	Retail: 20% co-insurance Mail order: $20 co-pay/prescription or 20% co-insurance, whichever is greater ($30 max co-pay), Deductible does not apply	Retail: 20% co-insurance	
	Tier 3 (Non-preferred brand drugs)	Retail: 25% co-insurance Mail order: $25 co-pay/prescription or 25% co-insurance, whichever is greater ($60 max co-pay), Deductible does not apply	Retail: 25% co-insurance	
	Specialty drugs	Retail: 25% co-insurance Mail order: $25 co-pay/prescription or 25% co-insurance, whichever is greater ($60 max co-pay), Deductible does not apply	Retail: 25% co-insurance	Specialty pharmacy services provider is available. Limited to 30-day supply. Preauthorization required for certain drugs.

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% co-insurance	50% co-insurance	None
	Physician/surgeon fees	20% co-insurance Deductible does not apply	50% co-insurance Deductible does not apply	None
If you need immediate medical attention	Emergency room care	20% co-insurance Deductible does not apply for treatment of accidental injury.	20% co-insurance Deductible does not apply for treatment of accidental injury.	Non-participating paid as participating if emergency medical condition.
	Emergency medical transportation Ground Ambulance Air Ambulance	20% co-insurance	20% co-insurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Preauthorization may be required.
	Urgent care	20% co-insurance Deductible does not apply for treatment of accidental injury.	50% co-insurance Deductible does not apply for treatment of accidental injury.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	50% co-insurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Preauthorization required for inpatient elective surgery.
	Physician/surgeon fees	20% co-insurance	50% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	20% co-insurance	None
	Inpatient services	20% co-insurance	20% co-insurance	Preauthorization required.
If you are pregnant	Office visits	20% co-insurance	50% co-insurance	Depending on the type of services, a co-payment or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% co-insurance	50% co-insurance	
	Childbirth/delivery facility services Free Standing Birthing Centers	20% co-insurance No charge	50% co-insurance 50% co-insurance	

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	Home health care	No charge	20% co-insurance	Limited to 100 four-hour visits/calendar year. Preauthorization required. No coverage for private duty nursing.
	Rehabilitation services Inpatient Outpatient	20% co-insurance 20% co-insurance	50% co-insurance 20% co-insurance	Preauthorization may be required for inpatient services. Outpatient limited to 30 visits combined per calendar year for most services. Includes physical therapy, speech therapy, occupational therapy, and pulmonary rehabilitation combined. Covered for restoring certain functional losses due to disease, illness, or injury only. No coverage for recreational therapy or maintenance services.
	Habilitation services Inpatient Outpatient	20% co-insurance 20% co-insurance	50% co-insurance 20% co-insurance	
	Skilled nursing care	50% co-insurance	50% co-insurance	Limited to 60 days/calendar year. Preauthorization required. No coverage for custodial care.
	Durable medical equipment	20% co-insurance	20% co-insurance	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 36 months, hearing aids for adults limited to $500 per 36 months and requires 50% co-insurance for participating and non-participating providers. Preauthorization required over $800.
	Hospice services	No charge	No charge	No coverage for private duty nursing.

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% co-insurance Deductible does not apply	20% co-insurance Deductible does not apply	Limited to one exam per 12 months.
	Children's glasses	No charge Deductible does not apply	No charge Deductible 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 Deductible does not apply	No charge Deductible does not apply	Preventive examinations every 6 months. Age 19 and over, benefit is limited to $250 per person first calendar year of eligibility; $1,250 per person each calendar year thereafter.

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.)

- Cosmetic surgery
- Custodial care
- Infertility treatment
- Long term care
- Outpatient recreational therapy
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care (limited to 52 visits/year)
- Dental care (Adult)
- Hearing aids (limited to $500 per 36 months)
- Non-emergency care when traveling outside the U.S.
- 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: 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, the U.S. Department of Labor www.dol.gov, Employee Benefits Security Administration at 1-866-444-3272 or 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.

* For more information about limitations and exceptions, see the plan or policy document at www.eugene-or.gov/EmployeeBenefits

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 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

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 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.

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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 coinsurance** ` **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,210**

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 coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$100
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,170**

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

- **The plan's overall deductible** **$150**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$5
Coinsurance	$530
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$685**

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