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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	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: $30/individual or $100/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?	$1,100/individual medical $1,350/individual pharmacy	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, balance-billing charges, charges of an alternative care provider, 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. Your 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: $15 co-pay/visit. Teladoc: No charge. Deductible does not apply.	$15 co-pay/visit plus 50% co-insurance	Teladoc consults: No charge only if Teladoc account activated through PacificSource. Standard co-insurance and/or deductible apply for other telemedicine services.
	Specialist visit	$15 co-pay/visit	$15 co-pay/visit plus 50% co-insurance	None
	Other practitioner office visit Acupuncture Chiropractic Care Massage Therapy Registered Dietician Naturopath	 $15 co-pay/visit $15 co-pay/visit $15 co-pay/visit $15 co-pay/visit $15 co-pay/visit	 $15 co-pay/visit $15 co-pay/visit $15 co-pay/visit $15 co-pay/visit $15 co-pay/visit	Naturopath, acupuncture, chiropractic care, dietician, and massage therapy limited to a combined 12 visits/calendar year. Dietician limited to one visit/year. No coverage for drugs, homeopathic medicines/supplies, and maternity.
	Preventive care/screening/Immunization Routine Physicals Well Baby/Child Visit Newborn nurse home visit Routine Gynecological Exam Tobacco Cessation Immunizations Preventive Colonoscopy COVID-19 vaccine, testing and related services	 $15 copay/visit $15 copay/visit No charge $15 copay/visit No charge No charge $15 copay/visit No charge	 $15 copay/visit plus 50% coinsurance $15 copay/visit plus 50% coinsurance $15 copay/visit plus 50% coinsurance $15 copay/visit plus 50% coinsurance No charge 50% co-insurance $15 copay/visit plus 50% coinsurance No charge	Limited to: Routine Physicals / Well Baby: one in-hospital exam for newborn plus 6 additional visits ages 0-12 months, 2 per year ages 1-2, and annually ages 2 and older. Newborn nurse home visits: up to age 6 months. 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 preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% co-insurance	None
	Imaging (CT/PET scans, MRIs)	No charge	50% co-insurance	None

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

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 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 copay or 50% coinsurance, whichever is greater Mail: $15 copay	Retail: $10 copay or 50% coinsurance, whichever is greater Mail: $15 copay	Retail limited to 34-day supply. Mail limited to 90-day supply. Preauthorization required for certain drugs. Retail and mail order subject to out-of-pocket limit of $1,350/year. Once out-of-pocket limit reached, copays for drugs obtained from a participating pharmacy are waived for the remainder of the year. Differential between generic and brand drugs, and non-participating pharmacy charges do not apply to the Rx out-of-pocket limit.
	Tier 2 (Preferred brand drugs, some Generic drugs)	Retail: $25 copay or 50% coinsurance, whichever is greater Mail: $25 copay	Retail: $25 copay or 50% coinsurance, whichever is greater Mail: $25 copay	
	Tier 3 (Non-preferred brand drugs)	Retail: $40 copay or 50% coinsurance, whichever is greater Mail: $50 copay	Retail: $40 copay or 50% coinsurance, whichever is greater Mail: $50 copay	
	Specialty drugs	Retail: $40 copay or 50% coinsurance, whichever is greater Mail: $50 copay	Retail: $40 copay or 50% coinsurance, whichever is greater	Specialty pharmacy services provider is available. Limited to 30-day supply. Preauthorization required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	No charge	50% co-insurance	None
If you need immediate medical attention	Emergency room care	$60 copay/visit	$60 copay/visit plus 50% coinsurance	Co-pay waived if admitted. Non-participating paid as participating if emergency medical condition.
	Emergency medical transportation	$50 copay/transport	$50 copay/transport	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Preauthorization may be required.
	Urgent care	$15 copay/visit	$15 copay/visit plus 50% coinsurance	None

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 hospital stay	Facility fee (e.g., hospital room)	$60 copay/day	$60 copay/day plus 50% coinsurance	Co-pay subject to 5-day max. 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	No charge	50% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	$15 copay/visit plus 50% coinsurance	None
	Inpatient services	$60 copay/day	$60 copay/day plus 50% coinsurance	Co-pay subject to 5-day max. Preauthorization required.
If you are pregnant	Office visits	$25 copay/pregnancy	$25 copay/pregnancy plus 50% coinsurance	Cost sharing does not apply for preventative services. Depending on the type of services, a co-payment, co-insurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$60 copay/day	$60 copay/day plus 50% coinsurance	
	Childbirth/delivery facility services	$60 copay/day	$60 copay/day plus 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	50% co-insurance	Preauthorization required. No coverage for private duty nursing.
	Rehabilitation services Inpatient	$60 copay/day	$60 copay/day plus 50% coinsurance	Co-pay subject to 5-day max. Limited to 30 days/condition in 12 month period; 60 days in 12 month period if head or spinal cord injury. Preauthorization required. Prescription required.
	Outpatient	$15 copay/visit	$15 copay/visit plus 50% coinsurance	Limited to 30 visits/12 months; up to 30 additional visits if neurological condition. Prescription required. No coverage for recreation therapy.

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)	
	Habilitation services Inpatient	$60 copay/day	$60 copay/day plus 50% coinsurance	Co-pay subject to 5-day max. Limited to 30 days/condition in 12 month period; 60 days in 12 month period if head or spinal cord injury. Preauthorization required. Prescription required.
	Outpatient	$15 copay/visit	$15 copay/visit plus 50% coinsurance	Limited to 30 visits/12 months; up to 30 additional visits if neurological condition. Prescription required. No coverage for recreation therapy.
	Skilled nursing care	$60 copay/day	$60 copay/day plus 50% coinsurance	Co-pay subject to 5-day max. Limited to 60 days/calendar year. Preauthorization required. No coverage for custodial care.
	Durable medical equipment	20% co-insurance	50% co-insurance	Limited to: power-assisted wheelchairs require Preauthorization; $200 for glasses or contact lenses to correct specific vision defect from severe medical or surgical problem; 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 $500.
	Hospice services	No charge	50% co-insurance	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 Medical Plan	$15 co-pay/visit	$15 co-pay/visit plus 50% co-insurance	One exam/24 months through age 18.
	Vision Plan	20% co-insurance	20% co-insurance	Limited to one exam per 12 months. Coordinated with Medical Plan.
	Children's glasses	No charge	No charge	For children under age 19. Prescription frames and lenses OR contacts (limit once every 12 months). See plan document for specific limits on contact lenses.
	Children's dental check-up	No charge	No charge	Preventive exam every 6 months. Age 19 and over, benefit is limited to $300/person first calendar year of eligibility; $1,300/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.)

- Bariatric surgery
- Cosmetic surgery
- Custodial care
- Long term care
- Non-emergency care when traveling outside the U.S.
- 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
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- 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	$0
Specialist copayment	$15
Hospital (facility) copayment	$60/day
Other coinsurance	0-50%

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	$0
Copayments	$180
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$260**

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$60/day
Other coinsurance	0-50%

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	**$5,800**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$1,510
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,680**

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$60/day
Other coinsurance	0-50%

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	$0
Copayments	$215
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$275**

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